# MOMENTUM

Country and Global Leadership

Case Study

# ADVANCING ADOLESCENT- AND GENDER-RESPONSIVE HEALTH SYSTEMS IN KENYA

October 2024

## PURPOSE

Adolescent- and gender-responsive health systems integrate evidence-based adolescent-friendly, gender-sensitive elements into all the health system building blocks. This approach intentionally shifts the emphasis from creating separate adolescent-friendly spaces towards ensuring that all health services are responsive to the needs and rights of adolescents and take into consideration the unique gender constraints adolescents face.[1] To advance understanding of how to strengthen adolescent- and gender-responsive health systems, MOMENTUM Country and Global Leadership (MOMENTUM) led a three-year initiative in two counties in Kenya. This case study summarizes the processes, results, and lessons learned from this initiative. **Drawing on the findings, we argue that employing an adolescent- and gender-responsive approach to health systems, facilitated by a novel assessment tool, is feasible and has the potential to drive improvements within subnational health systems.** We offer recommendations on how to apply an adolescent- and gender-responsive health systems approach to more sustainably improve adolescents' and youth's access to and use of quality health and nutrition services at scale.

## INTRODUCTION

Adolescence is a critical developmental phase marked by rapid physical, cognitive, and psychosocial growth.[2] However, the health needs of adolescents have historically not been given the same level of attention as those of other demographic groups.[3,4] Across different contexts, adolescents face elevated levels of early and unintended pregnancy, HIV/AIDS, malnutrition, mental health challenges, substance abuse, violence, and accidental injuries.[5–8] These health challenges stem from a range of different biological, social, and structural factors, including the fact that adolescents face significant barriers to accessing and using high-quality care. Barriers include distance, cost, inconvenient opening hours, fear of judgment, disrespectful treatment by providers, provision of incomplete information and services, and restrictions on what services they can seek without permission from parents or partners.[9,10] Furthermore, women and gender minorities face gender inequality and power disparities within the health system that inhibit their ability to access quality health

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services and practice positive health behaviors.[11] This is even more pronounced for adolescents due to the intersection of their gender identity and age, and can be further compounded by other intersectionalities, such as socio-economic status, ethnicity, geographic location, disability, and more.[7,12]

For decades, the primary approach to tackle the inadequate quality and accessibility of health care for adolescents has been to create adolescent-friendly health services, where the emphasis is on individual health facilities.[13] Typically, this involves training health care providers in adolescent-friendly services and setting up separate stand-alone spaces within health facilities where adolescents can receive services. However, while this approach has demonstrated effectiveness, it has been criticized for its limited scalability and sustainability, resulting in many adolescents still lacking access to health care.[1] To better align with the growing emphasis on universal health coverage and person-centered care,[*] and to more effectively address the needs of adolescents—who constitute a quarter of the population in many countries—it is essential to move beyond individual, facility-based approaches. Instead, gender-equitable adolescent health considerations should be meaningfully integrated into all aspects of the health system to ensure sustainable outcomes.[14]

The World Health Organization (WHO) and other stakeholders have proposed an adolescent- and gender-responsive health systems approach that focuses on integrating gender-sensitive, adolescent-friendly elements into all health system building blocks, ensuring that a comprehensive package of services is accessible, acceptable, equitable, appropriate, and effective for adolescents across various settings, such as health facilities, schools, workplaces, communities, and digital platforms. This approach intentionally shifts the emphasis from creating separate adolescent-friendly spaces towards ensuring that all health services are responsive to the needs and rights of adolescents, including consideration of the unique gender constraints they face. The approach reinforces person-centered care that extends beyond the conventional focus solely on adolescent sexual and reproductive health (ASRH), encompassing additional critical aspects such as nutrition, mental health, drug and substance abuse, sexual and gender-based violence, and accident and injury prevention. This broader perspective acknowledges the multifaceted nature of adolescent well-being and the interconnectedness of various health determinants.

The responsive-systems approach is relatively new. It was introduced by WHO in 2014, included in the WHO Accelerated Action for the Health of Adolescents (AA-HA! Framework) in 2017, and articulated in the 2020 update to the High Impact Practices Enhancement on adolescent responsive contraceptive services.[1,7,14] However, the adoption of this approach has been limited, with only a small number of countries, partners, and donors actively taking a systems approach to meeting the health care needs of adolescents at scale.

Since its inception, MOMENTUM has spearheaded global leadership and country-level actions to expedite the transition to an adolescent- and gender- responsive systems approach. As part of this initiative, MOMENTUM led the development of an adolescent- and gender-responsive health systems assessment tool with significant contributions from the U.S. Agency for International Development (USAID), WHO, and stakeholders in the pilot countries of Kenya and Sierra Leone. The tool aimed to make the concept of responsive systems practical and feasible. It enables ministries of health (MOHs), civil society, nongovernmental organizations (NGOs), and adolescents to assess whether and how the health system currently responds to the needs and rights of adolescents, including how the system acknowledges and addresses gender barriers and opportunities that influence adolescents' receipt of quality care.[15] Text Box 1 provides a brief description of the tool.

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*According to the World Health Organization, person-centered care is an approach that ensures everyone has equal access to quality health services, which are co-created to meet their needs throughout different stages of life while respecting their individual preferences.

### Box 1: Is your health system adolescent- and gender-responsive? A participatory tool for analysis and action planning

- The tool uses the WHO health systems building blocks as the primary organizing framework with the addition of the community-building block.
- There is one section for each building block: leadership and governance, service delivery, health workforce, health information, essential commodities and technology, financing, and community.
- Each section lists features of the building block that would make the health system more adolescent- and gender-responsive and provides four benchmarks for each feature (a score of 0–3). The features were determined through a review of the literature to identify which features have contributed to more accessible, acceptable, equitable, and effective services for adolescents. Additionally, input was gathered from practitioners in health systems, gender, and adolescent health.
- The tool can be used in a variety of ways, but MOMENTUM recommends a participatory process engaging adolescents as well as health system stakeholders in reflection and dialogue to agree on the score for each feature in the tool.
- It is important to note that the tool is not designed to determine the quality or adolescent-friendliness of a particular health facility or service delivery point, but rather to provide a picture of how the health system, at either subnational or national level, is serving adolescents.

From 2020 to 2023, MOMENTUM conducted a three-phase learning initiative in Turkana and Samburu counties of Kenya that aimed to enhance understanding of how governments and local partners can implement adolescent- and gender-responsive systems and explore how subnational health systems improved to meet the needs and rights of adolescents of all genders. First, this case study presents the methods used to conduct the responsive health systems assessments and to learn about the process of strengthening the health system to be more adolescent- and gender-responsive. Then, the case study articulates the findings from the initial adolescent- and gender-responsive health systems assessment and the changes identified during the follow-up assessment two years later. Finally, the case summarizes the facilitators and challenges of advancing an adolescent- and gender-responsive health systems approach in Samburu and Turkana counties and offers recommendations to others interested in supporting a transition to a responsive systems approach.

# LEARNING CONTEXT AND METHODS

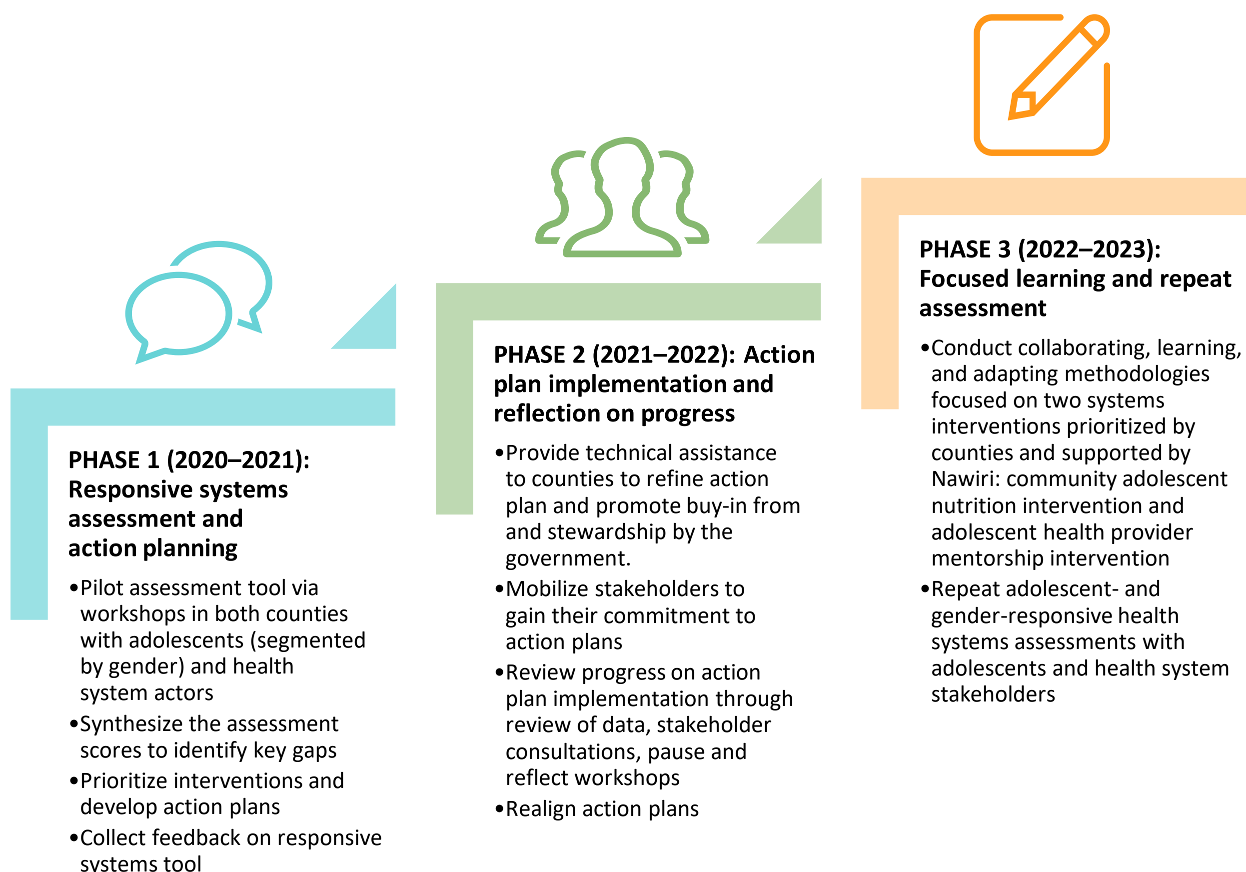
Turkana and Samburu counties are in the northwest of the country (Figure 1). They are characterized by high levels of poverty, food insecurity, poor state of infrastructure and social services, highly inequitable gender norms, and poorer health outcomes compared with national averages in Kenya. For example, according to the Kenya National Bureau of Statistics, the adolescent pregnancy rate is 50% in Samburu and 19% in Turkana, compared with 15% nationally. Moreover, among currently married adolescent and adult women (aged 15–49), 52% in Samburu and 49% in Turkana state that they make their own decisions about sexual relations, contraceptive use, and reproductive care, compared with 65% nationally. And, 29% of adolescents and women aged 15–49 in Samburu and 20% in Turkana experienced physical violence in the 12 months prior to the survey, compared with 16% nationally.

**FIGURE 1: LOCATION OF SAMBURU AND TURKANA COUNTIES, KENYA**

Adolescent malnutrition is a significant public health problem in Kenya, negatively affecting girls and boys in different ways. According the 2022 Kenya Demographic Health Survey, 18% of adolescent women and girls and 43% of adolescent men and boys are underweight. Samburu and Turkana have the highest percentages of underweight or thin adolescent girls (ages 15–19), with rates of 38% and 13% respectively. Among adolescent girls, 13% were either overweight (11%) or obese (2%), while only 3% of boys fell into the overweight/obese category.

MOMENTUM embedded the pilot of the adolescent- and gender-responsive systems assessment tool and subsequent learning activities within the USAID-funded Nawiri project, which is a health, nutrition, and food security project led by Mercy Corps with Save the Children and others as partners. Together with the Nawiri team and the county health system stakeholders, MOMENTUM facilitated three phases of technical assistance and collaborating, learning, and adapting methodologies, as shown in Figure 2. The methodology and process for each of the three phases is described below.

**FIGURE 2: MOMENTUM'S PHASED PILOT AND IMPLEMENTATION LEARNING APPROACH**




## PHASE 1: RESPONSIVE SYSTEMS ASSESSMENT AND ACTION PLANNING (2020–2021)

In 2021, MOMENTUM piloted the adolescent- and gender-responsive health system assessment tool in both counties. As described in Text Box 1 (above), the tool uses the WHO health systems building blocks as the primary organizing framework with the addition of the community building block. There is one section for each building block. Each section lists features of the building block that would make the health system more adolescent- and gender-responsive and provides four benchmarks for each feature that can be used for participatory joint assessment and scoring. Figure 3 is a screenshot of a section of the tool.

### FIGURE 3: SECTION OF THE MOMENTUM ADOLESCENT- AND GENDER-RESPONSIVE HEALTH SYSTEM ASSESSMENT TOOL

## BUILDING BLOCK 3: HEALTH WORKFORCE

| Feature | Benchmarks | | | | Score and notes |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | |
| **3.1 Competencies: There are national competencies for health workers in adolescent health, and they are included in the national pre-service education curriculum for all cadres.** | There are no national adolescent health competencies for health workers. | There are national adolescent health competencies, but they are not addressed in the national pre-service education curriculum. | There are national adolescent health competencies, and they are addressed in the national pre-service education curriculum for some (but not all) cadres. | There are national adolescent health competencies for health workers, and they are addressed in the national pre-service education curriculum for all cadres. | |
| **3.2 Competencies: There are national competencies for health workers in gender-sensitive service delivery, and they are included in the national pre-service education curriculum for all cadres.** | There are no gender-sensitive service delivery competencies for health workers. | There are gender-sensitive competencies, but they are not addressed in the national pre-service education curriculum. | There are gender-sensitive competencies and they are included in the national pre-service education curriculum for some (but not all) cadres. | There are gender-sensitive service delivery competencies for health workers, and they are included in the national pre-service education curriculum for all cadres. | |
| **3.3 Respectful care: Routine training, mentorship, or supervision provide systematic opportunities for facility, community, and school-based providers to reflect on their values and change attitudes and behaviors toward adolescents.** | No opportunity for reflection and attitude change. | Ad hoc opportunities for reflection and change in one-off training or meetings only. | Systematic opportunities for reflection and dialogue as part of supervision, mentorship, routine training or meetings for some cadres only. | Routine supervision, mentorship, pre-service, and in-service training all have opportunities for reflection and dialogue for all cadres. | |

The assessment was conducted through a two-step process: 1) initial consultations with adolescents to gather their perspectives, and 2) subsequent workshops with health system stakeholders.

Adolescent consultations were purposefully diverse, encompassing various age groups, genders, life stages, marital statuses, and urban/rural backgrounds. Facilitators, matched by gender, conducted separate sessions for adolescent girls and boys to foster open dialogue. The consultations used a customized version of the assessment tool, tailored for relevance and comprehension among adolescents, with facilitators using probes to explore health care service perspectives and gender-specific concerns. Facilitators rated participant responses using a scoring system (0–3).

The subsequent workshops with health system actors included subcounty and county health management teams (SC/CHMT), health facility managers, adolescent health providers, community health promoters (CHPs), and NGO representatives. Importantly, the workshop participants also included adolescent representatives who provided invaluable insights into their unique perspectives, needs, and experiences within the health system. Facilitators used the assessment tool to guide discussions on each health system component, integrating perspectives from adolescent consultations to enrich deliberations and validate viewpoints. Additionally, the discussions incorporated data from existing sources, including Kenya Health Information System records, Nawiri formative research reports, and government policy documents.

Results were consolidated in a user-friendly Excel dashboard format with color-coded visuals that aided stakeholders to quickly grasp the status of each health system building block.

Based on assessment findings, workshop participants prioritized interventions to strengthen adolescent and gender-responsive health systems. The prioritized actions are listed in Figure 4. Emphasis was placed on addressing identified weaknesses and targeting areas for immediate improvement (quick wins). The county

health department assumed ownership of the resulting action plans, disseminated them to relevant county government departments and partners, and sought financial and technical assistance for coordinated implementation.

### FIGURE 4: ACTIONS THAT WERE PRIORITIZED IN BOTH COUNTIES

**Leadership and governance**: Disseminate and promote use of national guidance documents at county, subcounty, and facility level. Include adolescents and youth as CHPs, members of community health committees, and health facility management committees. Make county-level adolescent technical working group functional and effective for coordination.

**Service delivery**: Shift focus from separate youth corners to offering adolescent health services in all service delivery points, including through community-based outreaches and CHPs.

**Health workforce**: Embed adolescent health and gender competencies in existing supervision and mentorship systems. Include opportunities to reflect on values towards serving adolescents and improve respectful care.

**Health information**: Provide training and structural changes for data storage to ensure privacy and confidentiality of adolescent clients. Review and act on age- and sex-disaggregated data during quarterly data review meetings.

**Financing**: Include adolescent health priorities in county and subcounty annual budget.

**Community**: Strengthen county adolescent technical working group to increase coordination between efforts to address social barriers to adolescent health and efforts to improve service delivery.

## PHASE 2: IMPLEMENTING THE ACTION PLANS AND REFLECTING ON PROGRESS (2021–2022)

Phase 2 involved a collaborative process to implement the action plans formulated in Phase 1, following the health system assessment. Led by the county health department, and through the existing multi-stakeholder technical working group (TWG), efforts were made to secure the backing and support of diverse stakeholders for the plans' implementation. Notably, various departments within the county governments incorporated some of the actions into their annual work plans, indicating a commitment to implementing them at a structural level. Similarly, NGO partners, such as the Nawiri project, integrated specific actions into their project plans and aligned their interventions with the goal of advancing the responsive-systems approach.

Alongside implementation of the action plans, MOMENTUM facilitated learning activities to gain a deeper understanding of the process and results of implementation of the adolescent- and gender-responsive action plan. The learning activities conducted in Phase 2 are summarized in Table 1.

### TABLE 1: LEARNING METHODS USED IN PHASE 2

| Method | Purpose | Participants |
| --- | --- | --- |
| **Document review, including field activity reports, annual workplans, progress reports, and health management information system data** | Identify how action plan items were incorporated into county and NGO partner workplans and budgets | Review conducted by MOMENTUM team |
| **Rapid pulse polls** | Gather feedback from a diverse array of stakeholders and gauge their perceptions of how the action plans have progressed and the county health system's responsiveness to adolescents and gender | 65 participants drawn from CHMT, SCHMT, health service providers, NGO and faith-based organization representatives, and members of the Nawiri Adolescent Advisory Councils |
| **Informal conversations** | Assess the progress achieved in implementing action plans and strengthening the adolescent- and gender-responsiveness of the health system | 18 participants representing CHMT, SCHMT, health service providers, implementing partners, and Nawiri Adolescent Advisory Councils |
| **Pause and reflect workshops** | Participatory and comprehensive examination of successes, challenges, enabling factors, and emerging lessons | 47 participants including CHMT, SCHMT, implementing partners, and members of Nawiri Adolescent Advisory Councils |

## PHASE 3: FOCUSED LEARNING AND REPEAT ADOLESCENT- AND GENDER-RESPONSIVE SYSTEMS ASSESSMENT (2022–2023)

Implementation of the action plans continued in Phase 3, with the county governments taking the lead and NGO partners providing technical and financial support to address gaps. The Nawiri project provided targeted health systems strengthening support at community, health facility, and subcounty and county levels to foster adolescent- and gender-responsiveness.

During this phase, MOMENTUM's learning activity delved deeper into two Nawiri-supported health system interventions: *community-based adolescent nutrition* and *facility-based provider mentorship on adolescent health*. The CHMTs and Nawiri developed these interventions in response to findings from the adolescent- and gender-responsive health systems assessment. MOMENTUM's learning approach aimed to document the process, acceptability, feasibility, the resulting system changes, and ultimately the impact on adolescents' uptake of health and nutrition services. The findings from this phase of learning have directly informed adaptations to the two interventions through a partnership between Nawiri and the CHMTs.

Phase 3 learning included key informant interviews, in-depth interviews, focus group discussions, pulse polls, and lessons-learned meetings as shown in Table 2, with a total of 189 unique individuals across both counties.

### TABLE 2: LEARNING METHODS USED IN PHASE 3

| Method | Purpose | Participants |
|---|---|---|
| **Semi-structured interviews** | To understand implementation of the adolescent nutrition and provider mentorship components and how they enhanced, or didn't enhance, the adolescent- and gender- responsiveness of the health system | Review conducted by MOMENTUM team |
| **Key informant interviews with C/SCHMT** | To gather experience and perspectives on implementing the two adolescent health and nutrition systems strengthening interventions | 65 participants drawn from CHMT, SCHMT, health service providers, NGO and faith-based organization representatives, and members of the Nawiri Adolescent Advisory Councils |
| **Focus group discussions** | To identify the enablers and barriers to implementing the community adolescent nutrition intervention<br>To explore participants' perspectives on the acceptability and feasibility of the community-based adolescent nutrition intervention | 18 participants representing CHMT, SCHMT, health service providers, implementing partners, and Nawiri Adolescent Advisory Councils |
| **Lessons-learned meetings and pulse polls** | To critically examine the experiences and contextual factors that shaped the effectiveness of the adolescent community nutrition and the provider mentorship components as interventions aimed at enhancing the adolescent- and gender-responsiveness of the health system | 47 participants including CHMT, SCHMT, implementing partners, and members of Nawiri Adolescent Advisory Councils |
| **In-depth interviews** | Explore adolescent health provider mentor and mentee perspectives and experiences implementing the mentorship approach | 10 participants (3 adolescent health provider mentors and 2 mentees in each country) |

MOMENTUM also analyzed data for the two interventions, including the number of adolescents (age 10-24) screened by adolescent mentors and CHPs for malnutrition based on the body mass index (BMI) and Mid Upper Arm Circumference (MUAC) and the number of those identified as malnourished who were referred to health facilities for counselling and nutrition support. The BMI cut off used was 17–18.5 for mild wasting, 16.0–16.9 for moderate wasting, and below 16 for severe wasting for non-pregnant and lactating adolescents while MUAC was used to screen pregnant adolescents where MUAC of below 23cm indicated risk of malnutrition as per the Kenya National Guideline for Integrated Management of Acute Malnutrition. For the provider mentorship component, MOMENTUM examined output data, including the number of providers mentored.

Finally, to evaluate changes to health system responsiveness since Phase 1, MOMENTUM facilitated a repeat assessment using the same workshop approach and respondent categories as the initial assessment (described under Phase 1, above). A total of 94 individuals (51 in Turkana and 43 in Samburu) participated in this second assessment. However, it is important to note that the repeat assessment used an updated version of the tool, which was informed by feedback from the first phase, and some individual participants were not the same who participated in the original assessment. Thus, direct pre-post comparison of the findings should be interpreted with caution.

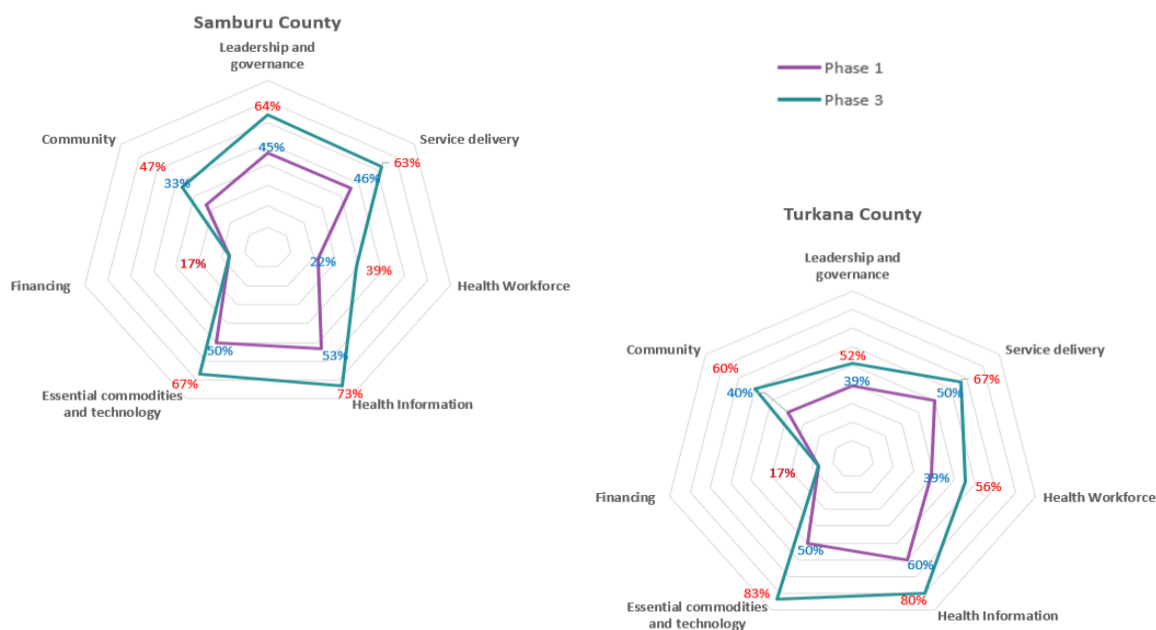
# KEY FINDINGS

This section triangulates findings from the three phases of learning. The section summarizes the gaps identified from the initial adolescent- and gender-responsive health system assessment, the actions that were prioritized, and the resulting improvements in the health systems. This section also provides a summary of the stakeholders' reflections on the key factors that enabled or constrained the achievement of the desired system changes.

## SUMMARY OF THE HEALTH SYSTEMS CHANGES ACROSS THE BUILDING BLOCKS

In both counties, the repeat adolescent- and gender-responsive health system assessment in Phase 3 (2023) found improvements to most health system building blocks when compared to the initial assessment conducted as part of Phase 1 (2021). Figure 5 shows how stakeholders scored each building block for their counties in Phase 1 and Phase 3, calculated as a percentage of the highest possible score in each building block. While there were slight variations between the two counties, the overall improvement was largely similar. All building blocks improved except for health financing, which had no change.

**FIGURE 5: CHANGE IN SCORE PER HEALTH SYSTEM BUILDING BLOCK AS DETERMINED BY THE PARTICIPATORY ADOLESCENT- AND GENDER-RESPONSIVE HEALTH SYSTEMS ASSESSMENTS CONDUCTED IN 2021 AND 2023**




## GAPS AND ACTIONS TAKEN FOR EACH BUILDING BLOCK

This section outlines the gaps in health system responsiveness that the health system officials, adolescents, and NGO partners in the two counties identified during the baseline assessment in 2021, the actions implemented by health system actors in the subsequent two years, and the resulting changes as identified during the second adolescent- and gender-responsive health systems assessment conducted in 2023.

### LEADERSHIP AND GOVERNANCE

At baseline in 2021, the dissemination of crucial policy documents like the National Guidelines for Provision of Adolescents and Youth Friendly Services remained largely limited to SC/CHMT, resulting in low awareness of policy provisions among service providers and stakeholders outside of government. This lack of awareness extended to adolescents, who were often uninformed about their health rights and available engagement mechanisms. Moreover, existing forums for adolescent participation are mainly located in urban areas or county headquarters, making them difficult for rural adolescents to access if they want to contribute to decision-making processes. Representation of adolescents in policy formulation and budgeting was sporadic and they were rarely included in accountability mechanisms. Additionally, health facility management committees frequently lacked adolescent representation, further marginalizing adolescent voices. Due to inadequate awareness of their health rights, adolescents rarely questioned the quality of services they received.

By the end of Phase 3, strides had been made to address these challenges. National Guidelines for Provision of Adolescent and Youth Friendly Services were disseminated more widely in both counties, with customized adaptations for local contexts in Samburu. Young people's involvement in the governance of health facilities was strengthened by appointing a youth representative who is a resident of the area and was nominated by a joint forum of local youth organizations. The initiative also included training the youth representatives on their

roles, which improved their active participation and capacity to articulate youth issues. Coordination among stakeholders improved notably through ASRH TWGs, which expanded their focus to encompass broader adolescent health issues, including nutrition, and welcomed new members from critical non-health sectors. The increased attention to adolescent health and nutrition within the broader health agenda was further bolstered by designation of focal persons for adolescent health and nutrition within county health departments. In Samburu, Amref Africa's Youth in Action (Y-ACT) project supported the empowerment of over 20 local youth organizations by enhancing their capacity to undertake youth-led advocacy and accountability initiatives. The emergence of assertive, well-informed, and confident advocates for adolescent issues contributed to amplifying adolescent and youth voices and agency in shaping health policies and services.

## SERVICE DELIVERY

At baseline, the provision of comprehensive adolescent- and youth-friendly services in some public health facilities was constrained by commodity shortages and inadequate staffing. There were previous attempts to establish stand-alone youth-friendly centers, which failed due to systemic issues like staffing and space constraints. Consultations with adolescents highlighted the challenges they faced accessing services at health facilities that were not open beyond the traditional operating hours. Partner-supported community outreach programs primarily focused on maternal and child health services, with limited attention to adolescent health. Additionally, while there were some ongoing quality improvement initiatives, they were inconsistent and lacked clear objectives for adolescent health and nutrition and gender equality.

The repeat assessment in 2023 found that health system actors incorporated adolescent and gender considerations into quality improvement processes, ensuring consistent attention to young people's unique needs. This was informed by the National Guidelines for Provision of Adolescents and Youth Friendly Services and WHO guidance.[16] For instance, adolescent health services were integrated into community outreaches in both counties, with the services extending beyond ASRH to include nutrition, counseling, and referral for sexual and gender-based violence (SGBV), mental health, and substance abuse. In some health facilities, focal people were appointed to coordinate services for adolescents and young people. In other facilities, adolescent health responsibilities were integrated into existing job roles across departments. Regular supportive supervision visits to health facilities by a multidisciplinary team of county and subcounty health managers were strengthened to include aspects of adolescent health and nutrition, which stakeholder perceived contributed to improved service quality. In Samburu, health facility service charters were revised to include standards for adolescent health services. In addition, participants in the assessments reported that some health facilities adopted flexible operating hours to enhance accessibility for adolescents.

## HEALTH WORKFORCE

Both counties suffer a persistent shortage of health workers, a challenge that is exacerbated by limited opportunities for refresher training for the few in place. While there were some in-service training sessions conducted sporadically by partners, they often did not cover aspects of adolescent health and nutrition or did not reach non-clinical staff. Similarly, supportive supervision and mentorship lacked consideration for providers' responsiveness to adolescents and gender considerations, thus failing to offer structured reflection on provider values, attitudes, and behaviors towards adolescents. Some providers and managers were unaware of WHO adolescent core competencies and admitted lacking interpersonal communication skills for adolescents. Tools for supportive supervision did not incorporate the core competencies or related performance metrics for health providers. These gaps contributed to judgmental attitudes by some service providers as illustrated by the quote below.

*"… because sometimes they ask too many questions, some that you wonder how they are related to the service you are seeking. Like they ask you whether you have a boyfriend, or why are you messing up with your life by being sexually active so young. Yes, I would say that health worker behavior depends on age. Adolescents and youth feel more comfortable with younger service providers because they can discuss freely and ask questions and they will understand each other. Older providers are seen as parents, and it becomes difficult to talk about some issues." Phase 1 interview,*
**—Adolescent Advisory Committee member, Samburu**

While shortages in the health workforce have persisted, the repeat assessment found ongoing efforts to address gaps in the adolescent competency of the available providers. With support from partners, the county governments provided in-service training and on-site mentorship targeting facilities and providers who served adolescents. Nawiri and the CHMTs in each county designed a comprehensive adolescent health and nutrition mentorship package, identified and trained a cohort of mentors, and facilitated periodic mentorship visits to health facilities. Text Box 2 provides a summary of the provider mentorship intervention, which serves as an important example of an adolescent-responsive systems approach that embeds adolescents into routine and existing quality improvement practices.

### Box 2: Spotlight on the adolescent health and nutrition provider mentorship intervention

- The adolescent health and nutrition provider mentorship intervention was developed to enhance the competencies of health care providers in addressing the specific health, nutrition, and gender-related needs of adolescents.
- Nawiri and the CHMT tailored the mentorship approach to address gaps identified in previous ad hoc efforts by standardizing the process and tools. The mentorship was done onsite to maintain service continuity and offer flexible, individualized mentorship aligned with mentees' needs and goals.
- The mentorship approach included four mentorship visits, which covered an individualized assessment of needs, mentorship on priority topics, and planning for the future. Sessions were documented in mentor and mentee logbooks, with feedback gathered in post-session debriefs to refine subsequent activities.
- Mentors were drawn from senior county health officials and technical experts who were trained as trainers. Mentors received an induction workshop emphasizing mentorship skills and were grouped into multidisciplinary teams for quarterly site visits. In 2023, 86 providers received tailored mentorship through the CHMT and Nawiri collaboration.

## HEALTH INFORMATION

At baseline, some routine health services data were disaggregated by sex and age, typically in five-year age groups, at both subnational and national levels, though intersex was not included as a separate category. Despite challenges in data completeness and quality, key adolescent health and nutrition indicators were routinely collected and used to monitor progress against annual work plans and targets. County health stakeholders used survey data to inform their plans and strategies, although they encountered resource

constraints in disseminating survey reports. Regarding data privacy and confidentiality, breaches were reported, especially for sensitive services like HIV and sexually transmitted infection screening, despite the existence of MOH guidelines and standards. As illustrated in the quote below, adolescents expressed mistrust in health care providers' commitment to confidentiality, citing poor explanations of data usage or alleged data leakage incidents.

> *"If you test positive for HIV, the information will be leaked to the general public the same day. The information will be all over the community. If I want to test for HIV, I had better do it at Archers Post where no one knows me. I will pay the cost of transport to go there instead of risking to do the test here."* **— Phase 1 focus group discussion with adolescents, Samburu County**

The repeat assessment found that NGO partners and the SC/CHMT in the two counties prioritized mentoring service providers and managers on skills in capturing, synthesizing, and using age and gender disaggregated data. Data quality audits were conducted during provider mentorship and quality gaps rectified on site. Further, during quarterly progress review meetings, stakeholders put more focus on monitoring adolescent health outcomes, including tracking adolescent uptake of key services such as contraceptive counseling and provision, antenatal care visits, skilled birth attendance, adolescents screened for malnutrition and referred for care, and HIV counseling and testing.

Additionally, service providers were re-oriented on the MOH's standards for data privacy and confidentiality. The training highlighted the importance of protecting adolescents' personal health information and reinforced the legal and ethical responsibilities related to data privacy. It also focused on creating a trusting environment where adolescents feel safe to discuss sensitive issues. Both counties re-evaluated their protocols for the secure handling and storage of health records, and supportive supervision visits reinforced measures to prevent unauthorized access to these records.

## COMMUNITY

While both counties made significant progress in implementing community health services, there were notable gaps in integrating adolescents as a target demographic. Historically, community-based services led by CHPs primarily focused on maternal and child health, with limited attention to the unique needs of adolescents. While these services included general health education and promotion, they lacked specific tailoring to address the diverse and evolving needs of adolescents, such as adolescent maternal and newborn health, sexual and reproductive health, mental health, and psychosocial support. To better serve this demographic, there is a need to adapt CHP services to be more adolescent-responsive, ensuring that the information, support, and care provided are relevant and accessible to young people.

Photo: CHPs and Boy anchor group mentor reviewing the anchor group register data.

Collaborations between the county government and partners for school-based outreach were sporadic due to

resource limitation. Additionally, linkages with programs and initiatives in the non-health sectors were weak. In both counties, there were deeply rooted gender norms that hampered uptake of health-promoting behaviors and services. A gender analysis conducted by Nawiri highlighted that girls and young women were disproportionately burdened with household chores, leaving them with limited opportunities to access health care.[17] The situation is aggravated by a powerlessness of women (and more so young girls who are married off early) who are denied the bodily autonomy to make decisions on their own health and especially related to reproductive health. Decisions such as whether or when to take up contraception are usually made by the husband or mother-in-law. Additionally, their mobility was often restricted, requiring them to be accompanied by a spouse or male chaperone, further limiting their access to services.

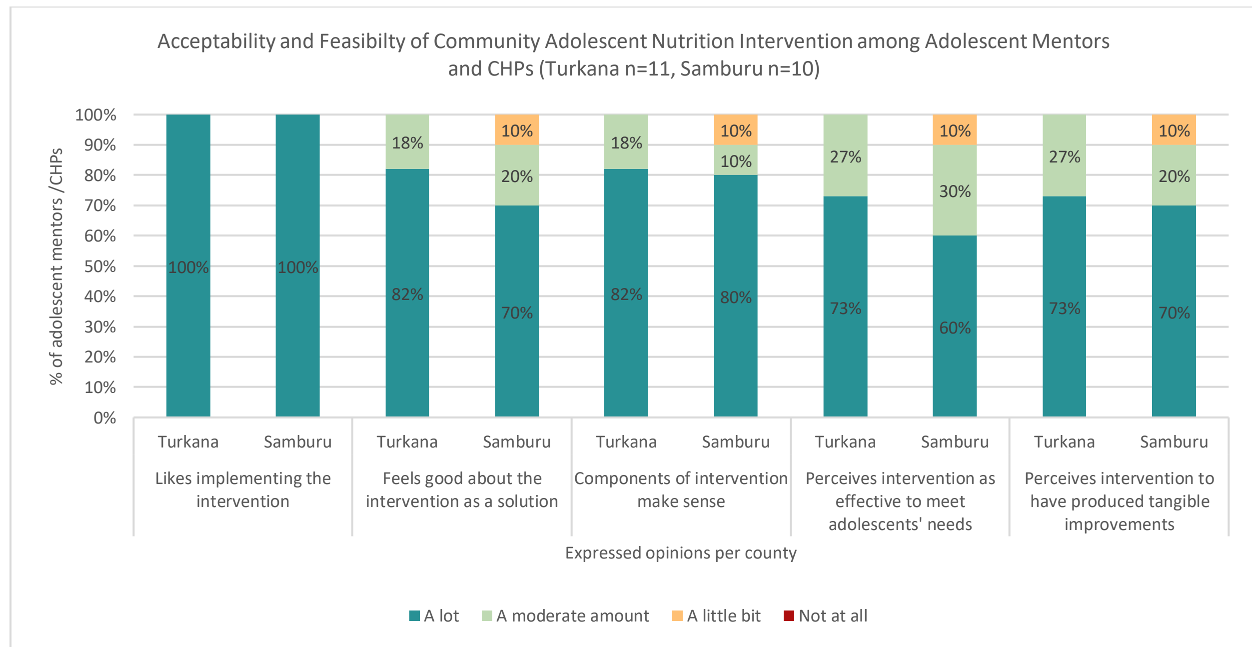
Between 2021 and 2023, the county governments and partners such as the Nawiri project supported the revitalization of CHPs through refresher training sessions, which included a focus on adolescent health, and improved linkage with health facilities for improved referral processes. Additionally, in collaboration with the CHMTs and in response to the findings from the initial adolescent- and gender-responsive health systems assessment, the Nawiri project introduced a novel adolescent nutrition approach. The approach, further described in Text Box 3, included training adolescent mentors to counsel their peers on health and nutrition, while integrating with other non-health and nutrition interventions, such as livelihoods support, economic empowerment, and vocational training. The adolescent mentors worked alongside CHPs to raise awareness on nutrition and conduct anthropometric measurements, identifying and linking malnourished adolescents, including pregnant and lactating adolescents, for facility referral and treatment. This approach serves as a strong example of how government and NGO partners can strengthen the responsiveness of the health system to meet the health and nutrition needs of adolescents at the community level.

### Box 3: Spotlight on the community adolescent nutrition approach

- The intervention aimed to address malnutrition and other vulnerabilities among adolescents through targeted strategies and community engagement.
- Household mapping and registration identified vulnerable adolescents, who were subsequently enrolled in specific small groups tailored to their needs. These included Girls Improving Resilience through Livelihood and Health, Transformative Masculinity, mother to mother support groups, and the Rural Entrepreneurial Access Program.
- The small groups served as safe spaces for adolescents to receive peer mentorship and health education. Trained adolescent mentors, supported by CHPs and local health facilities, conducted weekly sessions focusing on adolescent nutrition, ASRH, life skills, economic empowerment sessions, and monthly screening and referral for malnutrition.
- Malnutrition screening and referral were conducted jointly by adolescent mentors and CHPs, both trained in anthropometric measurements using mid- upper-arm circumference and BMI. CHPs verify and refer adolescents to the health facilities they are linked with. The CHPs and adolescent mentors received additional support through on-the-job mentorship from MOH and Nawiri staff.
- Regular supportive supervision from county health officials and Nawiri ensured program quality and adherence to protocols.
- By the end of the first year of implementation, nearly 12,000 adolescents had received nutrition counseling, and over 5,000 were screened for malnutrition. Mentors and CHPs referred 2,791 adolescents to local health facilities for broader health services and/or nutrition services in response to malnutrition.

Figure 6 illustrates the perceived acceptability of community adolescent nutrition interventions among adolescent mentors and CHPs across three dimensions: the comprehensibility of intervention components, satisfaction with the intervention as a solution, and alignment with adolescents' needs. Overall, the acceptability is highly positive, with over 80% of respondents expressing satisfaction with the intervention as a solution and finding the components understandable. Additionally, more than 60% believe the intervention adequately meets adolescents' needs.

#### FIGURE 6: ACCEPTABILITY AND FEASIBILITY OF THE COMMUNITY ADOLESCENT NUTRITION INTERVENTION AMONG ADOLESCENT MENTORS AND CHPS IN TURKANA AND SAMBURU COUNTIES




In addition, Nawiri worked with the CHMT to address gender-related barriers to care identified in the responsive-systems assessment. Understanding that some adolescent boys were hesitant to undergo malnutrition screening or seek treatment due to social norms that view young men as "warriors" defending their community, Nawiri incorporated tailored approaches to shift these gender and social norms within the community adolescent health and nutrition intervention. Furthermore, in collaboration with county governments and local partners, Nawiri promoted initiatives to involve adult and young men through peer groups. These groups aimed to challenge negative masculinities and gender-based norms that prevent the adoption of healthy behaviors and limit adolescents' access to health and nutrition services.

Other partners, including NGOs and faith-based organizations, helped to improve adolescents' access to services through outreach to schools and innovative strategies like providing nighttime services during cultural events (moonlighting). There were also NGO-led initiatives to collaborate with youth-led organizations to facilitate community dialogue sessions aimed at enhancing knowledge, promoting gender-equitable attitudes and norms, and encouraging positive health behaviors.

## HEALTH FINANCING

Insufficient funding for the health sector was an overarching challenge in both counties. The baseline assessment revealed that adolescents faced significant financial barriers that hampered service access. There were no specific strategies to cushion adolescents from user-fees, apart from a general government policy

that health services at primary care levels were free of charge while those at secondary and tertiary levels charge users. Adolescents noted discrepancies, reporting instances where supposed free services incurred charges at certain facilities. Additionally, intermittent shortages of drugs and limited availability of services like laboratory tests often forced adolescents to seek care at private or distant facilities, incurring additional expenses. With few adolescents covered by insurance, the national social insurance scheme had minimal impact on reducing their financial burden. Some previous pilots on demand-side financing failed to take root due to the county governments' inability to sustain them.

By the end of Phase 3, little progress had been made in addressing these challenges in adolescents' financial access to health care. In both counties, stakeholders expressed concerns regarding the insufficient allocation of budgetary resources, particularly highlighting the lack of emphasis on preventive and promotive health services. This fiscal constraint within the county budget limited the capacity to incorporate prioritized actions aimed at enhancing the responsiveness of the health system to adolescent and gender-related needs.

## KEY FACTORS CONTRIBUTING TO ADOLESCENT- AND GENDER-RESPONSIVE HEALTH SYSTEM CHANGES AND CHALLENGES: STAKEHOLDER REFLECTIONS

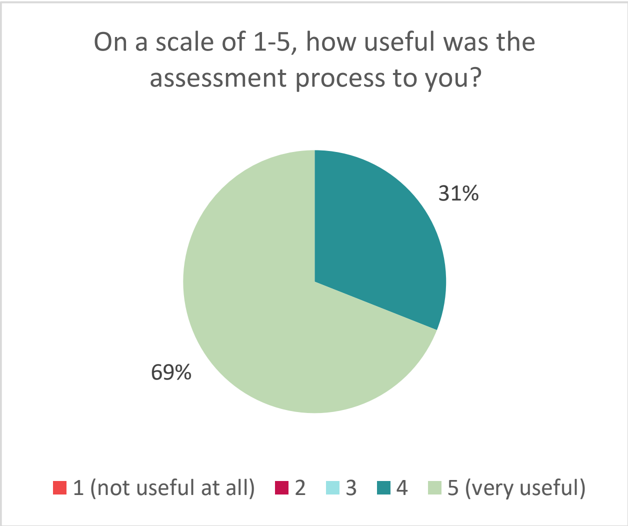
The Phase 3 learning offered stakeholders a valuable opportunity to thoroughly examine the factors—both obstacles and facilitators—that influenced the observed changes in the responsiveness of the health system at county level or, in some instances, stagnation. This introspective process allowed MOMENTUM and other stakeholders to gain insight into the dynamics shaping the transformation within the health system.

Below are **key factors that enabled improvements** to the adolescent- and gender-responsiveness of the health system in Samburu and Turkana counties.

### PARTICIPATORY PROCESS, GUIDED BY A VERSATILE TOOL

The participatory adolescent- and gender-responsive health systems assessment process helped identify areas for improvement and prioritize actions to address them, thus aligning the disparate efforts of multiple actors in the two counties. The adolescents and health system actors who participated in the assessment felt the process was useful (see Figure 7) and observed that the assessment tool was valuable in framing the shift towards an adolescent- and gender-responsive health systems approach.

**FIGURE 7: STAKEHOLDERS' FEEDBACK ABOUT THE ASSESSMENT TOOL AND PROCESS**




The assessment tool enabled a comprehensive understanding of the local context, allowing stakeholders to identify priorities and advocate for necessary changes. Moreover, it aided in the development, refinement, and implementation of action plans to address these priorities effectively. Additionally, its adaptable design allowed use across diverse contexts and at various stages of improving health system responsiveness. The assessment process also helped take stock of existing strategies, guidelines, and standards, thus serving monitoring and

accountability purposes. As the Phase 1 assessment was designed as a pilot and was the first time the assessment tool was used, the participants also provided valuable feedback for changes that MOMENTUM then incorporated into the tool for dissemination and for use in Phase 3. These suggestions are summarized in Text Box 4.

### Box 4: Suggested changes to the adolescent- and gender-responsive systems assessment tool based on pilot of the tool in Phase 1

- The tool was too long, particularly in the leadership and governance component, suggesting that features could be streamlined or merged to enhance efficiency.
- Consolidate to simplify (e.g., merge demand-side and supply-side financing aspects).
- Expand and more clearly articulate what elements of commodities and technologies might be appropriate to consider as part of an adolescent-responsive approach.
- Explain technical terms and reduce complexity throughout the tool to ensure accessibility for non-experts.
- Maintain structure using the WHO health systems building blocks framework as it facilitated a comprehensive and systemic approach to assessing adolescent health services, enabling assessors to evaluate these services holistically.

## SHIFT IN MINDSETS

There was a notable shift in the mindsets of planners and implementers from traditional approaches, such as vertical programming and youth-friendly corners, to a more holistic systems-thinking approach. This shift allowed for a broader understanding of the interconnectedness of various health system components. As illustrated by quotes below, stakeholders started to challenge the status quo, emphasizing the need for stronger integration to reflect the range of actions that can be taken to improve health services for adolescents, beyond provider training and separate rooms.

*"There is a challenge in applying the systems lens … people are just pulling to their side. Like sometimes you struggle to make people see why you need to integrate adolescent sexual and reproductive health in a nutrition program like Nawiri. I think there is lack of understanding on how the intervention feeds into the overall goal of sustainably reducing persistent acute malnutrition. Also, the connection that for good service provision to be at the facility, there are things that need to be done upstream and downstream to create an enabling environment of this to happen."*
***— Phase 1 participant, pause and reflect workshop, Turkana***

*"Initially, the ASRH focal points concentrated only on ASRH issues, but we have broadened their mandate to cover the wide spectrum of the health and nutrition of adolescent and young people. We now call them adolescent and young people health coordinators and we expect them to work closely with other colleagues such as those responsible for nutrition, SGBV, mental health, public health, school health, etc., for the purpose of integration."* ***— Phase 3 key informant, CHMT, Turkana***

## COUNTY GOVERNMENT OWNERSHIP

The county government's ownership and leadership of the adolescent- and gender-responsive health system action plans played a critical role in driving success. They focused on improving coordination among multiple stakeholders, which helped align individual efforts and achieve comprehensive system-wide changes. However, there is still some room for enhancing government stewardship and domestic resourcing for some aspects such as community outreaches and school health interventions that are currently largely dependent on vertical programs run by partners.

## EXPANDING THE FOCUS BY CONSOLIDATING MULTI-STAKEHOLDER EFFORTS

The involvement of multiple stakeholders (i.e., subcounty and county health officials, NGOs, civil society organizations) in the change process—which was coordinated through the TWGs—enabled delivery of a comprehensive package of adolescent health services. Beyond the traditional ASRH focus, stakeholders mapped out and consolidated ongoing initiatives that address other adolescent health needs, including nutrition, mental health, and SGBV. Additionally, county leaders recognized the complex interplay between health and broader social determinants and made efforts to strengthen linkages and integration with non-health sectors, such as education, agriculture, water and sanitation, and trade.

## ATTENTION TO CORE COMPETENCIES OF SERVICE PROVIDERS

The targeted approach taken in both counties to building adolescent health and nutrition competencies among health care providers was instrumental in enhancing the responsiveness of health systems. Stakeholders realized and emphasized the pivotal role of quality care as a cornerstone in responsive health systems, especially in fostering trust and confidence among adolescents and motivating them to seek and use health services. Notably, the provider mentorship intervention, supported by Nawiri, was particularly effective as it was embedded within the health system and employed flexible and adaptable teaching methods tailored to the individual needs of each mentee. Compared to traditional training workshops, the on-site mentorship approach allowed for continuity of service delivery by not withdrawing mentees from their service stations. Mentees also felt that the support provided was relevant to their context as illustrated by the quotes below.

> *"One thing that I appreciated most was the practical bit of the mentorship because it helped me to gain confidence in inserting the IUCD … showing me how to do it and then asking me to demonstrate it back to her and then observing me as I do it. Yah, … by the time she comes back for the next session I will have perfected the skill. So, yah, it helped a lot."*
> ***— Phase 3 interview with a mentee, Samburu County***

> *"The mentor was knowledgeable and very patient with me. She took her time to understand my challenges and capacity gaps and helped me to come up with options on how I could address those challenges. I felt that she appreciated the realities of working in a remote health facility where resources are very limited and where health awareness in the community is still quite low."*
> ***— Phase 3 interview with a mentee, Turkana County***

## STRENGTHENING ADOLESCENT AGENCY

In the two counties, youth mentorship, peer education, and inclusion in policy and decision-making processes were instrumental in fostering adolescents' autonomy, self-efficacy, and leadership skills. Notably, the systems assessment actively involved adolescents and young people, providing them a platform for their voices to be included in prioritizing actions to improve the health system. We also observed that the peer group approach used in both counties to tackle adolescent nutrition issues provided mentees with broader skills and support by enhancing their awareness on multiple health topics, increasing their economic stability through income-generating activities, and enabling access to education and vocational training opportunities. As is often the case with these types of interventions, the peer group model also benefited the mentors themselves, enabling them to adopt positive behaviors and become influential role models within their communities.

> *"As Samburu youth, we felt that we were not fully considered in the National Youth Friendly Services guideline and so we came together and incorporated our beliefs and culture and drafted a customized youth-friendly service for us and we believe it will encourage our youth to seek medication in health facilities."*
> ***— Phase 1 interview with Adolescent Advisory Council representative, Samburu County***

> *"When members start businesses using the VSLA [Village Savings and Loan Association] loans, their household income improves, and they are in a better position to afford a variety of food items and other basic needs. In my group, I have seen this happening, where members have set up chicken and goat rearing business and when they sell them, they have improved the status of their households."*
> ***— Adolescent mentor, Angata Nanyokie, Samburu County***

Despite enthusiasm for the responsive-systems approach among county management teams and stakeholders, there were **challenges that hampered progress** towards achieving adolescent- and gender-responsive health systems. These are described below.

## SUB-OPTIMAL COORDINATION AMONG HEALTH SYSTEM ACTORS

Projects and initiatives implemented by NGOs often operated independently and in parallel with government initiatives, despite pursuing similar objectives. This lack of coordination inhibits progress towards a more responsive health system. While Turkana and Samburu did make progress on coordination via the TWG, it required considerable effort to rally stakeholders around a unified plan for adolescent- and gender-responsive systems. Moving beyond information sharing to actionable cooperation took time and still requires significant effort to maintain momentum.

## POLICY AMBIGUITY

Stakeholders acknowledged the need for policy refinement to address uncertainties among providers regarding parental or spousal consent for adolescents, especially those seeking contraceptives. The absence of clear policy in this critical adolescent health service has left decision-making at the discretion of providers, giving room for moral arguments and potential inconsistencies in service provision. Lack of dissemination of the policy documents was also highlighted as a key challenge as illustrated below:

> *"You see, the MOH at the national government is responsible for developing policies and they do so really well, coming up with very nice policy documents, including guidelines. Where we have a gap is on dissemination because they do not cater for that and us, here at the county level, have no resources for that. Sometimes you see a very nice guideline or clinical protocol developed at the national level but the people it is meant for at the health facility level don't have access to it, or even do not know it exists. It is ridiculous, we need to rethink how to address this challenge."*
> ***— Phase 3 participant, health systems assessment workshop, Samburu***

## LACK OF GENDER POLICIES AND PRESENCE OF HARMFUL GENDER NORMS

The absence of supportive national policies for integrating gender considerations within the health system in Kenya proved a challenge to strengthening the gender-responsive elements identified by the baseline assessment and the adolescent- and gender-responsive action plans. Without national guidelines and policies supporting the integration of gender-responsive elements into the health system, the counties were less able to operationalize key elements of an adolescent- and gender-responsive health system. For example, there are no national gender competencies for providers to anchor provider training or mentorship.

In addition, stakeholders concurred on the enduring prevalence of inequitable gender norms and perceptions. In both counties, societal norms regarding masculinity manifested as barriers to adolescent boys' use of specific services. This phenomenon was particularly evident within the Nawiri project, where certain adolescent boys exhibited reluctance towards engaging in malnutrition screening or seeking treatment. This reluctance stemmed from societal expectations that young men should epitomize the resilience and stoicism associated with a traditional warrior archetype.

## LIMITED RESOURCES

Despite strong plans and good intentions, both counties struggled to implement all aspects of their adolescent- and gender-responsive health system action plans due to financial constraints. This was further evidenced by the fact that the adolescent- and gender-responsiveness of the finance building block of the health system did not improve meaningfully over time. For instance, despite the effectiveness of the provider mentorship intervention, the available funding was not sufficient to reach a critical mass of service providers and non-clinical cadres. Similarly, interventions were hampered by inadequate human resources, commodities, and equipment. The funding limitation underscores the need for strategic domestic resource allocation and innovative financing mechanisms to ensure the scalability and sustainability of strengthening adolescent-focused systems.

### POLITICAL INTERFERENCE

Adolescents in both counties cited some instances where political interests lead to biased representation of adolescents and youth, with politicians or power brokers favoring their associates for decision-making roles. This kind of interference can marginalize certain adolescents, dampening their enthusiasm for governance structures and processes.

> *"It does not always go smoothly; the politicians, like the local member of the county assembly, sometimes pick and choose the specific young people who will receive information on opportunities or who will be asked to offer suggestions on matters, where ideally the voice of a much more diverse group of young people should be the case. Due to this, many young people, especially those from marginalized groups, feel locked out of the decision-making platforms and processes."*
> ***— Phase 3 interview with Adolescent Advisory Committee representative, Turkana***

## CONCLUSION AND RECOMMENDATIONS

As illustrated in this case study, progress towards a comprehensive, adolescent- and gender-responsive health systems approach is possible. However, the process is neither straightforward nor linear. It is an ongoing iterative process of building upon what exists and leveraging opportunities for synergy across the individual pieces that stakeholders are implementing using a systematic approach. It calls for a systems-thinking mindset, multi-stakeholder ownership, government stewardship, and efficient multisectoral coordination.

The health system changes observed in the two counties are notable, yet significant work remains to make progress. MOMENTUM is unable to conclusively say if the changes to the health system are directly resulting in improvements in the uptake of services among adolescents and/or impacting health outcomes. This is largely due to three challenges: 1) changes in systems and the resulting uptake of services and impact on health outcomes takes time and most changes will only be observable in the coming years; 2) the lack of a counterfactual to understand what would have happened in the absence of the adolescent- and gender-responsive health systems approach; and 3) limited age-disaggregated service delivery data means tracking changes in uptake over time across counties is challenging.

In addition to the challenges in measuring impact, a crucial area requiring attention is the dominance of ASRH within health systems. As much as adolescents' sexual and reproductive health needs are not being met, health systems are actively working to improve these services, while adolescents' specific needs within other health areas, such as nutrition, mental health, SGBV, and non-communicable diseases, are given less attention. To ensure adolescent nutrition is prioritized within an adolescent- and gender-responsive health system, it is essential to integrate nutrition services and outcome measures—such as the percentage of underweight or thin adolescents—into training, mentoring, and data collection processes, such as the national health information system or county surveys. There is also a need to update national guidelines to integrate gender considerations and revise monitoring and evaluation indicators to focus on outcomes rather than just adolescent- and youth-friendly service outputs, such as number of youth-friendly centers established. Additionally, there's a notable overreliance on external support and donor funding for adolescent health services. There's a pressing need to reassess strategies to embed priorities for responsive systems into county budgets and work plans, fostering greater sustainability.

Drawing on MOMENTUM's learning, here are recommendations on how stakeholders can increase their chances of success in actualizing the paradigm shift to adolescent- and gender-response health systems:

- The transition to responsive systems must be firmly grounded in an **enabling policy and legal framework** that guarantees adolescents' rights to access the full spectrum of health services, irrespective of their age, marital status, or parity. This framework should uphold principles of equity and non-discrimination, recognizing adolescents as autonomous individuals with the right to make informed decisions about their health. Moreover, policies should explicitly stipulate that services be gender-responsive. In cases where gaps exist, action plans should incorporate advocacy efforts, led by adolescents and young people themselves, to address these shortcomings.
- Recognizing **meaningful engagement** as a fundamental right for adolescents, stakeholders should actively work towards creating environments that empower adolescent and young people to participate in decision-making processes affecting their health and well-being. The engagement should be intentional, inclusive, iterative, and mutually respectful as outlined in the High Impact Practice Strategic Planning Guide and emerging best practices on enhancing youth social accountability.[18–20]
- During the systems assessment and action planning, stakeholders should establish clear lines of **accountability** for overseeing action plan implementation. They should also define the process through which civil society stakeholders, including youth-led and women's rights organizations, can hold the government accountable. Furthermore, the team should decide on the frequency of accountability check-ins to **monitor progress on action plans** and how successes will be communicated. In the case of Kenya, county health system officials and NGO stakeholders found quarterly check-ins beneficial for ensuring progress on action plans. Additionally, it was agreed that the systems assessment would be repeated annually to track improvements in responsiveness and identify new areas of focus.
- As demonstrated in this case study, one of the game-changing priorities is improving **providers' adolescent and gender competencies** through mentorship and supervision, rather than only through training. The mentorship approach was particularly successful because it adopted a "whole clinic approach," ensuring that both clinical and support staff receive the necessary competencies to provide respectful and gender-sensitive care to adolescents. This approach fosters a shared commitment among staff to serve adolescents and assigns complementary responsibilities in constructing a responsive health system.
- Given that many interventions for adolescent health occur outside the health sector, it is critical to facilitate **intersectoral collaboration** backed by effective governance mechanisms that harness collective expertise and resources to address the multifaceted determinants of adolescent health and well-being.
- As a standard, stakeholders should **integrate gender considerations** into multisectoral initiatives aimed at improving adolescent health and well-being, including addressing context-specific gender and social norms that underlie harmful health outcomes for both adolescent girls and boys. While WHO does not have gender competencies, there are tools and frameworks that have been implemented in the field with promising results and could be adopted to build the gender competencies of stakeholders involved in this endeavor.[21–23]
- Lastly, there is a critical need for continuous learning, documenting, and sharing evidence on effective strategies to catalyze the transition to adolescent- and gender-responsive health systems. Stakeholders can integrate collaborating, learning, and adapting practices into their transition journey, to ensure that successful practices are identified, documented, and disseminated widely, fostering a collective understanding of what works and enabling iterative improvements in health system responsiveness to adolescent and gender-specific needs.

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## Suggested Citation

MOMENTUM Country and Global Leadership. *Advancing Adolescent- and Gender-Responsive Health Systems: A Case Study from Kenya.* 2024. Washington, DC: USAID MOMENTUM.


## Acknowledgements

MOMENTUM Country and Global Leadership recognizes the leadership of Save the Children Kenya and Faith Chesang and Kimani Karuga (consultant) in the implementation of this body of work. We also recognize the technical contributions of MOMENTUM Country and Global Leadership staff, including: Callie Simon, Elizabeth Arlotti-Parish, Habtamu Fekadu, Ben Stephens, Victoria Lwesha, Alicia Hansen, and Delaney Ward.


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