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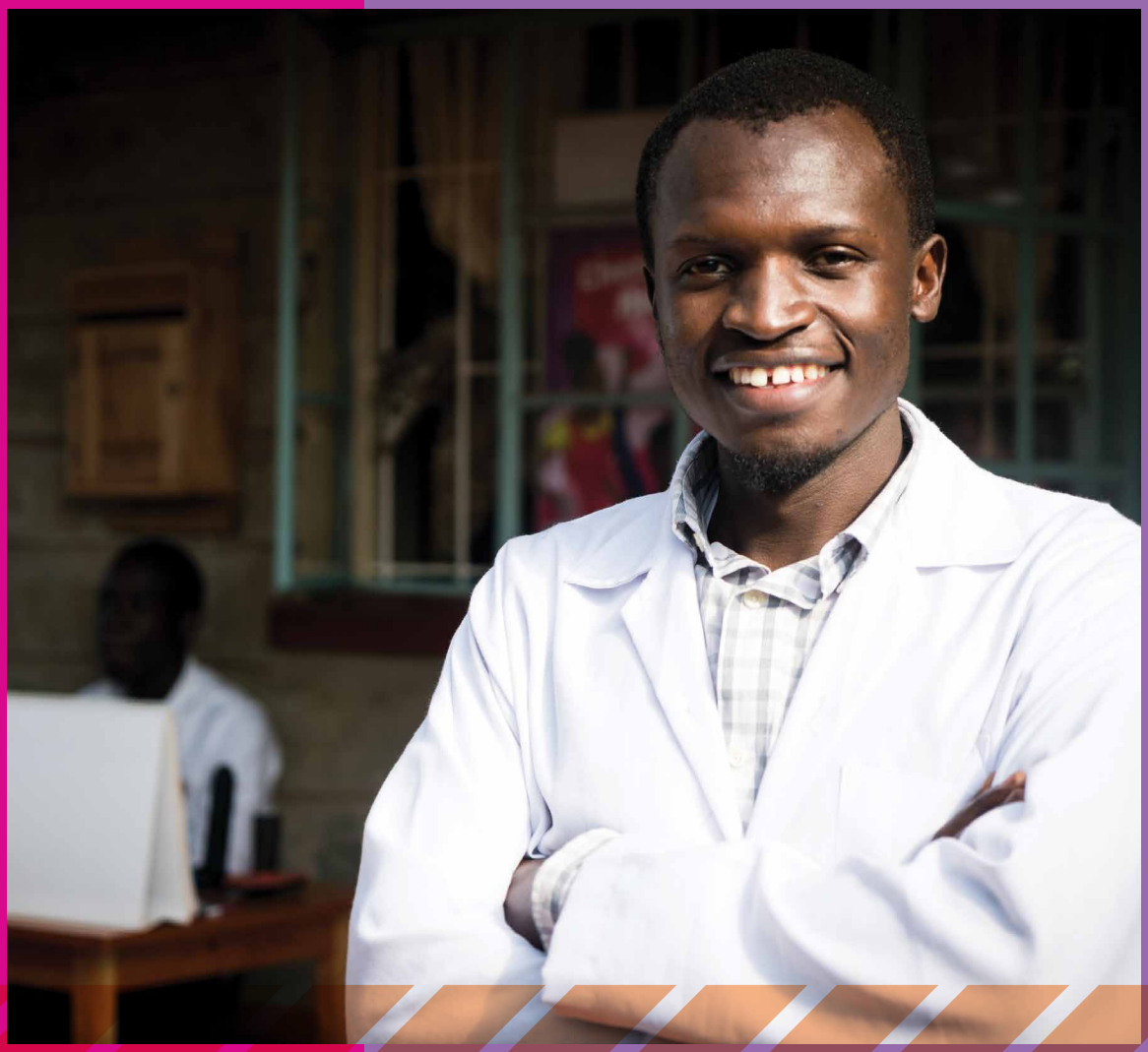
Gender transformative approaches to improving youth SRHR

Improving the sexual and reproductive health and rights of young people in Kenya by training healthcare providers in the GTA



Gender transformative approaches to improving youth SRHR: Improving the sexual and reproductive health and rights of young people in Kenya by training healthcare providers in the GTA

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Executive summary

Introduction

This report presents the findings of operational research with healthcare providers who offer youth-friendly sexual and reproductive health services to young people in six counties in Kenya. The focus of the study was gender transformative training for healthcare providers. Could we understand the effects of the training on their gender and sexuality-related attitudes and beliefs and on the quality and inclusiveness of the sexual and reproductive health services they provide to young people, especially women and girls?

This study was part of the Get Up Speak Out (GUSO) programme, that focuses on young people's access to and utilisation of comprehensive sexual and reproductive health and rights education and services, as well as on improving and creating a supportive environment for their sexual and reproductive health and rights. GUSO is implemented in seven countries in Africa and Asia; Kenya is one of those countries, where the programme is implemented by the Kenya SRHR Alliance.[1]

When young people seek a sexual and reproductive health service they will meet and interact with a healthcare provider. Healthcare providers therefore play a key role in the provision of sexual and reproductive health services to young people. According to international organisations including the World Health Organization, youth-friendly sexual and reproductive health services should be based on principles like confidentiality and non-judgmental and respectful care.[2] Unfortunately, young people and adolescents are not always well received in health facilities. They encounter providers who are judgmental, who treat them rudely, or who even deny them services. Healthcare providers in Kenya report being torn between personal feelings, cultural and religious values and beliefs and their wish to respect young people's rights to access and obtain SRH services.[3] There is wide recognition that negative attitudes from healthcare providers, also referred to as provider bias, are a key barrier to young people's rights to access quality and youth-friendly sexual and reproductive healthcare.[4]

While there have been interventions to improve healthcare providers' capacities and skills in youth-friendly SRHR, there is a gap in evidence on what interventions are effective in minimising provider bias. Building on wide consensus that provider bias stems from broader social norms, this study sought to understand if applying a gender transformative approach to SRHR service provision could be effective in minimising provider bias rooted in attitudes and beliefs. A gender transformative approach stimulates increased awareness and critical thinking on gender and power imbalances by addressing their root causes. It aims to stimulate a process of transformation that starts at the individual level, influencing attitudes and behaviour to become more equitable. Rutgers has developed a comprehensive toolkit for implementing its Gender Transformative Approach (GTA) in sexual and reproductive health and rights programmes and has trained an international group of 18 GTA master trainers.[5]

1. https://www.srhralliance.or.ke/
2. World Health Organization's Guidelines on Making health services adolescent friendly
3. Godia, P., Olenja, J. et al. (2013) and Tumlinson, K., Okigbo, C.C. et al. (2015)
4. Solo, J. & Festin, M. (2019)
5. See: https://www.rutgers.international/Gender-transformative-approach/resources

What is unique and effective in the Rutgers GTA model is that it combines six interconnected, key principles that could be integrated into activities, programmes, strategies and policies. The six key principles are:

1. Embracing a human rights-based approach
2. Critically addressing and transforming harmful gender norms
3. Critically addressing and transforming unequal power relations
4. Empowering girls and women
5. Engaging men and boys
6. Embracing gender and sexual diversity

Gender transformative SRHR interventions ideally focus on norm change at all levels of the socio-ecological model: the individual, interpersonal, organisational, community and public policy level.

Methodology

Twenty-four healthcare providers, providing sexual and reproductive health and rights services to young people in Kenya, participated in two intensive training sessions covering different aspects of GTA. After the training, the healthcare providers kept a diary for a period of five months in which they reflected on their consultations with young people. Every two weeks they submitted their diary entries to the research team who then reviewed them and reflected on them with each healthcare provider. This, it was hoped, would allow healthcare providers to reflect on their own gender attitudes and the role these play in their service provision to adolescents and young people. Over the five month period, 146 diary entries were submitted. The healthcare providers also filled in surveys on gender attitudes at baseline and endline and participated in focus group discussions at endline to reflect on the GTA training and the effect it had on their attitudes and beliefs around gender and sexuality and on their service provision to young people. Data from young people on their experiences with sexual and reproductive health services were collected through eight focus group discussions (with a total of 61 young people, 30 males and 31 females) at baseline and 46 exit interviews (13 males, 33 females) at endline. Finally, six interviews were held with key informants, reproductive health coordinators at county

level and health facility managers. All interviews were recorded, transcribed verbatim and analysed thematically by two senior researchers. Ethical approval was obtained from the AMREF Ethical and Scientific Review Committee in Nairobi, Kenya.

Key findings

Gender and sexuality-related norms can have negative effects on young people's access to and utilisation of SRHR services. At the start of the study the most common obstacle for young people that restricted their access to SRHR services was the importance attached in religious and community beliefs to sexual abstinence before marriage. Young people felt that especially negative judgments were made of young women who engaged in premarital sex. Some of the healthcare providers believed that sexually active young people, in particular young women and HIV-positive young people, were promiscuous and irresponsible. Many also held negative views against sexual diversity. This resulted in different types of provider bias, ranging from patronising attitudes to denial of services and breaching of confidentiality and privacy. Increased knowledge on gender and power through GTA training and being involved in the reflective process of keeping diaries triggered critical reflection on their own personal attitudes.

This quickly had positive effects on how they interacted with young people coming to their clinics. Key changes observed were increased skills in making young people comfortable through attentive listening and assuring privacy and confidentiality, more appreciation for young people's SRH rights and the ability to talk about young people's SRH issues without judgment, engaging young men in ways that addressed their SRH needs and that supported young women's reproductive health decision-making, and more positive attitudes to young people with diverse sexual orientations and gender identities. Healthcare providers were also able to challenge harmful sexual and gender norms in their counselling sessions with young people and to give them positive and hopeful messages. These changes contributed to more young people seeking SRHR services in the studied facilities.

Discussion

The report provides evidence that GTA training contributed to changing unfavourable gender and sexuality-related attitudes and beliefs of healthcare providers into more supportive ones, and of improvements in service delivery that positively impacted on how young people perceived and received SRHR care. These changes were sustained over the period of the study. Self-reflection, achieved in this study through diary writing, was a powerful tool for triggering changes in attitudes. The study contributes to emerging evidence around what interventions work to minimise provider bias.

Recommendations

Based on the findings of this study, these are some recommendations for sustaining current GTA activities and future implementation of new GTA activities in sexual and reproductive health programmes:

National level stakeholders

1. Engage with the ministry of health, the county departments of health and higher education learning institutions to mainstream GTA in healthcare provider training

SRHR CSOs and practitioners

1. Establish GTA mentors who can follow up with GTA-trained healthcare providers to fulfil a helpdesk/support function
2. Recognise/celebrate some of the good practices seen after the GTA intervention to keep healthcare providers motivated to keep up such practices and to inspire others
3. Encourage health facilities to incorporate GTA training into the inception of new healthcare providers
4. Ramp up efforts to create a more enabling environment in the community for gender transformation
5. Simplify the language around GTA to make it easier to grasp and work with
6. Make use of the network of certified GTA master trainers

Future GTA research

1. Measure long-term GTA intervention effectiveness and test out tools that measure implicit and explicit provider bias
2. Conduct ethnographic studies to create a more in-depth understanding of different social norms and their role in influencing attitudes and behaviour of healthcare providers
3. Set up similar studies to add to the emerging evidence on the effectiveness of GTA to minimise certain types of provider bias

Selected recommendations for youth-friendly service providers and facilities made by young people

1. Healthcare providers should receive training on providing services to young people in a friendly and non-judgmental way
2. Expand the working hours of youth-friendly services to include weekends and evenings
3. Healthcare providers should close the doors during consultations to maintain privacy and to make you feel that anything you say is confidential
4. Healthcare providers should sensitise the community about young people from diverse sexual orientations and gender identities so that they are not stigmatised and their confidence is built
5. Healthcare providers should create more awareness in the community about young people's SRHR issues; this would also create more demand
6. Ensure that every facility has enough male and female youth-friendly healthcare providers that young people can choose whether to seek services from a male or female
7. Make SRHR services more attractive and welcoming for boys

Foreword

It's Friday evening at around 6 pm. Yeah, this is late, but no, it is not too late for a moonlight activity,[6] which is going on up to 10 pm. Two youths walk into the tent holding hands, a sign of happiness. Mike, 22, and Milly, 20, have been dating for a while, but they keep having a reoccurring issue – Mike doesn't want Milly to conceive since they are still in school, but he also doesn't want her to use any method of contraceptive. As Milly describes their story to me, I realise that there is more sadness in this relationship than happiness, because Milly is being forced, however sweetly, to do things that she isn't comfortable with – like having unprotected sex.

I explain it simply: if she gets pregnant it will not only be her own problem, but both of their problems because they are both in school and they are not that well to do. Mike interrupts and tells me that Milly is very aware of herself and can't let that happen, she will always take care not to get pregnant. I explain that this idea that women will always take care of themselves is just a norm: in a relationship where both people enjoy together they should also share together on what to do and what not to do. I ask Mike, if he was a girl could he allow someone to make decisions for him without his involvement?

He says no, which I applaud him for and inform him that in this generation we should always get our heads together to agree. He breathes heavily then proceeds to say that truly there is sense in that explanation and for sure he will always ask her to say what is best for her. Milly smiles and says a lot of thanks. I take them through all the available contraceptives after which I ask them to go make an informed choice together so when they come back next time they have decided together what they want.

A diary entry by Zopher, one of the healthcare providers in this study, demonstrating how well youth-friendly SRH services can be delivered when steps are taken to broaden access (the timing of the service), to be welcoming and non-judgmental, to listen, and to challenge gender norms, all of which were encouraged by the Gender Transformative Approach training he participated in.

6. 'Moonlight activities' are mobile services, for example SRHR activities, during evening hours

Abbreviations

AMREF	African Medical and Research Foundation
AIDS	Acquired immune deficiency syndrome
CSO	Civil society organisation
FGD	Focus group discussion
GBV	Gender-based violence
GTA	Gender-transformative approach(es)
GUSO	The Get Up Speak Out programme
HCP	Healthcare professional
HIV	Human immunodeficiency virus
IPPF	International Planned Parenthood Federation
KII	Key informant interviews
LGBTQ	Lesbian, gay, bisexual, transgender, queer
NGO	Non-governmental organisation
SGBV	Sexual and gender-based violence
SRHR	Sexual and reproductive health and rights
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
YFS	Youth-friendly services
WHO	World Health Organization

Background

Study objectives

This reports presents findings of a piece of operational research that aimed to understand the effects of Rutgers Gender Transformative Approach (GTA) training on healthcare providers' attitudes and beliefs around gender and sexuality, and on the quality and inclusiveness of their sexual and reproductive health services to young people, especially women and girls. The specific objectives of the research were:

- To have a better understanding of the context-specific attitudes of healthcare providers regarding gender and the sexuality of young people, specifically young women and young people with diverse gender identities
- To have better knowledge of how such attitudes of healthcare providers are manifested in their interactions with young people during service provision
- To generate evidence on the effectiveness of a gender transformative approach to positively change the attitudes and sexual/gender norms of healthcare providers and to improve the quality and inclusiveness of SRH services for young people

Youth-friendly services and provider bias

The World Health Organization has developed guidelines on making services adolescent friendly, and defines friendliness in reference to the quality of services, to having competent, non-judgmental providers, awareness among adolescents of health services, and community support for services.[7] At the heart of such services are principles including: having trained providers who communicate with youth in a respectful and non-judgmental manner; facilities that have policies of confidentiality and privacy; facilities that have convenient hours and locations for young people; affordable fees; and youth participation.[8] Recently, some organisations have adopted more progressive definitions of youth-friendly services that focus on rights, diversity, gender and youth participation. For example, in the *Essential Packages Manual* developed by the Sexual and Reproductive Health and Rights Alliance, partners indicate that youth-friendly services should be based on a "comprehensive understanding of what young people need" and be respectful of the "realities of young people, their diversity and sexual rights".[9] This perspective understands the potential of youth-friendly services to advance human rights and transform norms that disadvantage certain groups of young people.

In sub-Saharan Africa, access to youth-friendly sexual and reproductive health services is expanding although challenges persist. Restrictive laws and policies, capacity of the healthcare system, lack of information, harmful cultural practices, and social norms are restricting young people's SRH and rights, and the ability to access and utilise SRH services. This is especially so for young women and girls, who meet sexual and reproductive health barriers that stem from power hierarchies and harmful gender beliefs. These barriers impede females from making informed decisions regarding contraception and increase their risk to sexual and gender-based violence.[10] There is wide agreement that negative

7. World Health Organization's Guidelines on making health services adolescent friendly
8. Interagency Youth Working Group: http://www.iywg.org/topics/youth-friendly-services
9. Essential Packages Manual: https://www.rutgers.international/our-products/tools/essential-packages-manual
10. Singh, S. & Darroch, J.E. (2012)

attitudes from healthcare providers, also known as provider bias, form an important barrier to realising youth-friendly services. A recent literature review on provider bias defines it as "judgmental, non-empathetic, and/or low-quality provider behaviours" targeted to certain groups of clients.[11]

Bias against provision of various contraceptive methods to young people is the most common type of provider bias and it often stems from broader social norms, particularly judgments about sexual activity among young people and concerns about the impact of hormonal methods of contraception on future fertility.[12]

Youth-friendly services and provider bias in Kenya

In Kenya, at least a third of adolescents aged 15-19 are sexually active, yet contraceptive use – although increasing – is low, with only 50% of sexually active females using any contraceptive method, and 49% of those using a modern form.[13] This results in high levels of unplanned teenage pregnancies: at least one fifth of female adolescents begin childbearing before the age of 19. In addition, HIV infection remains a big concern among adolescents in Kenya and affects female adolescents disproportionately: HIV prevalence among girls and women 15-24 years old is 2.6%, as opposed to 1.3% among their male counterparts.[14] Further, research shows female adolescents in Kenya run a disproportionally high risk of undergoing unsafe abortions and associated complications. Of all post-abortion care services sought from public facilities in Kenya, 17% are accounted for by female adolescents yet 74% of the moderate and severe complications that result from unsafe abortions are among this group.[15] According to the 2008-09 Kenya Demographic and Health Survey, 11% of women aged 15-19 and 20% of women aged 20-24 had experienced sexual violence.[16]

Kenya's National Adolescent Sexual and Reproductive Health Policy defines youth-friendly services as sexual and reproductive health services delivered in ways that are responsive to the specific needs, vulnerabilities and desires of adolescents and which should be offered in a non-judgmental and confidential way that fully respects human dignity.[17] The policy and the national guidelines for the provision of youth-friendly services identify healthcare providers and clinic staff as key players in ensuring that adolescents and young people access healthcare services. Service providers' personal beliefs and negative attitudes may hinder young people from accessing healthcare services. In addition, the healthcare providers may lack some of the knowledge and skills needed to attend to or implement services for young people. Healthcare providers report being torn between personal feelings, cultural and religious values and beliefs and their wish to respect young people's rights to access and obtain SRH services.[18] Adolescents are not always well received or comfortable in mainstream family planning clinics, which are mostly government-owned health facilities. They encounter providers who are judgmental, who treat them rudely, or who even deny them services.[19]

11. Solo, J. & Festin, M. (2019)
12. Kenya Demographic and Health Survey 2014
13. National AIDS Control Council. (2018)
14. African Population and Health Research Center. (2013)
15. Kenya Demographic and Health Survey 2008-09
16. Kenya Ministry of Health. (2015)
17. Godia, P., Olenja, J., Lavussa, J., Quinney, D., Hofman, J & Broek, N. (2013)
18. GUSO 2017 *"Get Up Speak Out" baseline report Kenya*. Gitau, T., Kakai, T., Kuster, L. & Kok, M. (2017) and Hagey J.M., Akama E., et al. (2015)
19. Solo, J. & Festin, M. (2019)

When healthcare providers adopt a Gender Transformative Approach, what are the benefits?

While there have been interventions to improve healthcare provider capacities and skills in youth-friendly SRHR, there is a gap in evidence on what interventions are effective in minimising provider bias. There exists wide consensus that provider bias stems from broader social norms.[20] Also, evidence shows that programmes and training that include a gender and power perspective are substantially more effective at achieving positive health outcomes, such as reducing rates of unintended pregnancy, unsafe abortions or sexually transmitted infections, than programmes which don't incorporate these elements.[21] This study sought to apply a gender transformative approach (GTA) to SRHR service provision as an approach to minimise provider bias rooted in attitudes and beliefs. A gender transformative approach generates increased awareness and critical thinking on gender and power imbalances by addressing their root causes. It aims to stimulate a process of transformation that starts at the individual level, influencing attitudes and behaviour to become more equitable. When healthcare providers participate in GTA training, their service provision can become more equitable, ultimately benefitting the SRH outcomes for the young people they serve. Rutgers has developed a comprehensive toolkit for implementing the Gender Transformative Approach in sexual and reproductive health and rights programmes and has trained an international group of 18 GTA master trainers.[22] This study used the introductory module (Module 1) and the module on applying GTA principles to YFS (Module 3). What is unique and effective in the Rutgers GTA model is that it combines six interconnected, key principles that can be integrated into activities, programmes, strategies and policies. When healthcare providers adopt a gender transformative approach, they can:

- Place human rights at the centre and focus on agency and rights of young people
- Address harmful norms and values underlying gender inequality and violence
- Understand and address unequal power relations
- Empower girls and young women to make informed decisions
- Engage adolescent boys and young men as an essential part of the solution
- Provide sexual and reproductive services to young people from all sexual and gender diversities

Gender transformative SRHR interventions ideally focus on all levels of the socio-ecological model, as they intersect; these include the individual and interpersonal level but also a person's environment, e.g. school, workplace, health centre, community, media and government.

21. Haberland, N. & Rogow, D. (2015)
22. Rutger's GTA Resources: https://www.rutgers.international/Gender-transformative-approach/resources

THE GET UP SPEAK OUT PROGRAMME

Get Up Speak Out (GUSO) is a five-year programme (2016-2020) developed by a consortium consisting of Rutgers, Aidsfonds, CHOICE for Youth and Sexuality, Dance4life, International Planned Parenthood Federation (IPPF) and Simavi. The programme is financed by the Dutch Ministry of Foreign Affairs under the SRHR Partnership Fund.

The GUSO programme addresses the following problem: "Young people do not claim their sexual rights and their right to participation because of restrictions at community, societal, institutional and political levels. This hinders their access to comprehensive SRHR education and services that match their needs, and ability to make their own informed SRHR decisions." The GUSO programme is implemented in seven countries: Ghana, Ethiopia, Indonesia, Kenya, Malawi, Pakistan and Uganda. It aims to empower all young people, especially girls and young women, to realise their SRHR in societies that take a positive stance towards young people's sexuality. The programme uses a multi-component approach by focusing on access to and utilisation of comprehensive SRHR education and services as well as improving and creating a supportive environment for SRHR.

The theory of change describes five interrelated outcomes that contribute towards the long-term objective. These interrelated outcomes are:

1. Strengthen in-country SRHR alliances
2. Empower young people to voice their rights
3. Increase the access to and utilisation of SRHR information/education
4. Increase the access to and utilisation of sexual and reproductive health (SRH) services
5. Improve and create a supportive environment for SRHR

The Rutgers Gender Transformative Approach (GTA) is one of the five core guiding principles of the GUSO programme.

Methodology

Research participants and study tools

To allow sufficient time to document any changes occurring in attitudes and beliefs of healthcare providers and their effects on service provision, healthcare providers were followed over a period of five months that built in several moments of data collection. A schematic overview of the timing of the different data collection moments and the methods used can be found in Annexe 1.

Healthcare providers

Data collection took place across health facilities in six counties in Kenya where the GUSO programme is implemented: Nairobi, Kisumu, Kakamega, Siaya, Homa Bay and Bungoma.[23] In total, 20 health facilities were involved in the study: 15 public health facilities, a community health facility, a private medical centre and three non-governmental organisation (NGO) facilities. Six of the health facilities were located in urban areas, and 14 were based rurally. All of the health facilities included already offered youth-friendly services (mostly integrated youth-friendly services); only two of the facilities were standalone youth-friendly facilities. Most of the youth-friendly services in the study operated from 8 am to 5 pm, Monday to Friday. Some of the public health facilities had community health volunteers attached to them who worked in communities and in the YFS. From these 20 facilities, 24 healthcare providers (14 males and 10 females) including nurses, clinical officers, community health volunteers (CHVs) and peer providers who primarily provide sexual and reproductive services to young people, participated in the study. Healthcare providers were in the age range from 24 to 52 years, with the majority being in their thirties. The healthcare providers had been working under the GUSO programme in their respective facilities and had been trained on the sexual and reproductive health needs of young people prior to participating in this study. Over a period of five months, the healthcare providers participated in the following data collection methods:

Survey

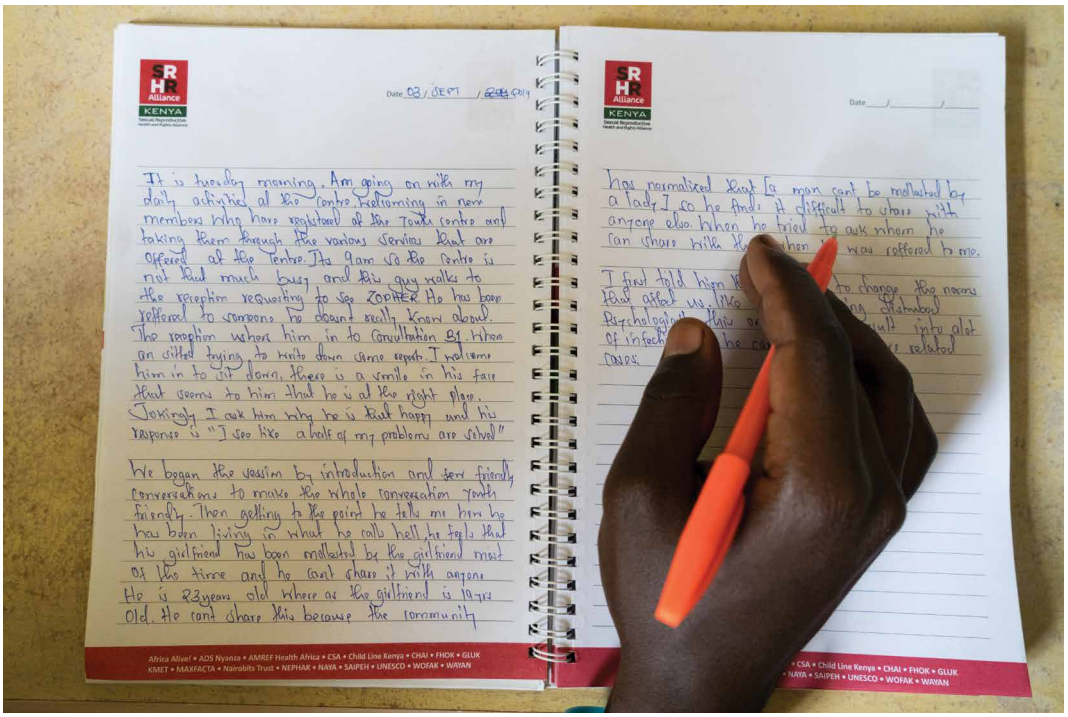
At the start of the first GTA training, the healthcare providers were given a self-administered survey to measure views and attitudes on young people's sexual relationships, reproductive health and disease prevention, sexual and gender-based violence, sexual and gender diversity and a section to measure stigmatising attitudes towards young populations. Towards the end of the study this survey was repeated to capture changes in these attitudes. Some of the survey questions were adapted from specific questions in the Gender Equitable Men (GEM) scale[24] and these were supplemented with questions measuring unfavourable attitudes regarding service provision to young populations.

Focus group discussions

Towards the end of the study healthcare providers participated in focus group discussions that focused on changes experienced in gender and sexuality-related attitudes and on how they applied what they had learned in the GTA training to their sexual and reproductive health service provision to young people.

23. In Kenya, GUSO is implemented by the SRHR Alliance through nine member organisations. The following organisations are involved in the implementation of YFS: Family Health Options Kenya (FHOK), Tropical Institute of Community Health and Development (TICH), Kisumu Medical Education Trust (KMET), Centre for the Study of Adolescence and Women Fighting AIDS in Kenya (WOFAK), which are health service delivery and support organisations.

24. Nanda, G. (2011)



Diary writing

During the five month study period the healthcare providers kept a diary describing one or more cases of encounters with young people to whom they provided services each week. They described what type of services the young person sought and also details of their interactions with them: how they welcomed them, what tone of voice they used, what questions they asked them and what information they provided to them. Finally, they reflected in their diary entry on this encounter: what went well, what would they improve next time, what effort did they make to break harmful gender/sexual attitudes and norms, and what effort did they make to be responsive to the needs of this particular young person. The diary entries were submitted to the research team. The research team reviewed the diary entries and provided feedback either through a face-to-face meeting or via phone or email. Many diaries improved over time in the detail of information captured and the quality of reflections on their own work. A total of 146 diary entries were submitted over the course of the study.[25]

Three healthcare providers dropped out towards the end of the study because of work transfers or personal reasons and could not participate in the focus groups or endline survey.

Young people

Immediately after the first GTA training, eight focus group discussions (separate discussions for young men and young women) were held with 61 young people (30 male, 31 female) aged between 15 and 25 years old, who were sampled from the catchment areas of the facilities where the healthcare providers were working. Of the 61 participants, 32 said that they received training or information on sexual and reproductive health and rights issues before and 54 had previously visited a clinic to access sexual and reproductive health services. Questions centred around availability of and access to SRH services for young people, social norms around young people's sexuality, delivery of services by healthcare providers, their experiences of accessing services and suggestions to improve sexual and reproductive health services. Towards the end of the study, 46 client exit interviews were

25. The few healthcare providers who submitted fewer diary entries mentioned a heavy workload, challenges with internet access, or a lack of stories to write about as reasons for not submitting regular diary entries

held with 33 female and 13 male adolescents and young people in the age range of 15 to 25. Nearly all of these young people had received SRH services from one of the healthcare providers participating in the study either on the day of the interview or in the two weeks prior to the interview. The client exit interview focused on how young people experienced the service provision, especially the interaction with the healthcare provider.

Key informants

Key informants, four county and sub-county Reproductive Health Coordinators and two facility managers of health facilities, were interviewed. The key informants were knowledgeable about the SRH services and activities in their areas. They elucidated their knowledge of inclusive SRH services and the application of gender transformative approaches (if any), the capacity of health facilities to implement and deliver youth-friendly services using a gender transformative approach, and the support available for such services.

Gender Transformative Approach training

Two intensive training sessions on gender transformative approaches in YFS formed the core of this study. During this training, the 24 healthcare providers engaged in experiential learning sessions about the application of a gender transformative approach to their work. The training was run by two training facilitators from the international group of 18 GTA master trainers trained under the GUSO programme. Experiential learning is learning through active participation. The sessions included introductory exercises to Rutgers Gender Transformative Approach and exercises specifically related to applying a more gender transformative approach in youth-friendly services. The main objectives of the first GTA training were to train the healthcare providers in the integration of a gender transformative approach in youth-friendly services, to make them critically aware of the need to do this, and to provide them with practical tools to do this. The objectives of the second GTA training were to share progress in applying GTA in health service provision to young people, and stimulate more self-reflection. An overview of the GTA training sessions, the educational techniques used and the intended outcomes, can be found in Annexe 2. The research team participated in both training sessions in order to document the reactions and discussions that took place between the healthcare providers in response to the training content and to record any transformation process that started during the training.

Data analysis

The study findings mostly consist of qualitative data gathered through interviews, focus group discussions and diary entries. The qualitative data were transcribed from digital recordings by two young Kenyan researchers. Using a thematic approach, the two senior researchers created a codebook by reading through a sample of the transcripts, and creating codes based on themes and sub-themes that emerged from the data. They compared codes and then coded all transcripts. Based on the main codebook, separate codebooks were created for each dataset (diaries, focus group discussions with young people, focus group discussions with healthcare providers and key informant interviews). Quantitative data from the surveys of healthcare providers and the exit interviews with young people, were analysed using SPSS. For the surveys with healthcare providers we assessed proportional differences of each statement per theme by gender, both at baseline and after the intervention.

Ethics

Ethical approval for this research was obtained from the African Medical and Research Foundation's Ethical and Scientific Review Committee (AMREF ESRC). Healthcare providers voluntarily agreed to participate in the study. Young people participating in the focus group discussions and exit interviews were between 15 and 24 years old. They were recruited with the support of the healthcare providers, based on the criterion that they had accessed SRHR services in their facilities. All study participants were assured that no names or other personal identifiers would be used in the final report. In their diary entries, healthcare providers wrote about services they had provided to young people who were between 10 and 24 years old. Healthcare providers were asked to use pseudonyms in their diary entries when writing about their clients. Consent to record conversations was obtained prior to initiating group discussions or individual interviews. All focus group discussions with young people were segregated by sex. Two young Kenyan researchers (one male and one female), with experience in doing research on sexual and reproductive health-related topics, facilitated the interviews and focus group discussions. Prior to the GTA training, a senior Kenyan researcher together with a researcher from Rutgers spent two days with the young researchers to finalise and pre-test the data collection tools and to discuss in depth several topics related to ethics. The two senior researchers coordinated the fieldwork and the senior researcher from Kenya co-facilitated some of the focus group discussions.

Study limitations

This study had several limitations. First, the healthcare providers participating in the study were geographically spread and some were working in very remote areas. This made it difficult for the research team to organise face-to-face meetings for collecting and reviewing diary entries. Second, the majority of facilities involved in the study are public health facilities. The impact of the intervention may vary if replicated for private healthcare providers. Third, the young people involved at baseline (through FGDs) and the young people at endline (through client exit interviews) were two different groups making it more difficult to measure change. Also, young people's answers may have been affected by desirability bias as the healthcare providers supported the research team in recruiting them. Nonetheless, substantial improvements in satisfaction with services and healthcare provider attitudes were documented and these were substantiated by improvements in provider attitudes documented in the survey and FGDs with healthcare providers. Finally, it is possible that other YFS-related activities of the Get Up Speak Out programme may have contributed to the effectiveness of the intervention.

Gender and sexuality-related norms in Kenya

Young people's awareness of gender and sexuality-related norms

Social norms are common rules constructed and shared by a group or community about socially acceptable or appropriate behaviour in particular social situations.[26] YFS providers are members of their own communities and have values and attitudes that are shaped significantly by these social norms. These attitudes inevitably play a role their service provision to young people. This section highlights some common norms about gender and sexuality held by young people and healthcare providers.

The FGDs showed young people were cognisant of social norms that control their sexuality. Young people noted that religions such as Islam and Christianity (in particular the Pentecostal Church) are against use of contraception:

> "We have some religious beliefs such that you find some churches they don't allow use of family planning methods completely. So that is a challenge for young youths who come from such a religion to come for the services." (FEMALE, 22 YEARS, FGD PARTICIPANT, SIAYA)

> "Most religious leaders will tell you 'Your body is like the temple of God – you need to keep it clean', therefore young people are discouraged from having premarital sex and wait until marriage." (MALE, FGD PARTICIPANT, KAKAMEGA)

Young men and women shared the belief that there is especially negative judgment towards young women who engage in sex. Social norms disapprove of young unmarried women engaging in sex and using contraceptives:

> "In my religion, that is Islam, having sex before marriage and use of contraceptives is not acceptable, therefore most girls will pretend especially when they are at home that they never engage in sex … We are not supposed to have sex until we are married. We are not supposed to use contraceptives. We are not supposed to talk about contraceptives." (FEMALE, 18 YEARS, FGD PARTICIPANT, SIAYA)

> "People view that maybe if you are a man and have sex before marriage there is no problem but if you are a girl or a lady if you have sex before marriage it is something considered very wrong." (FEMALE, 21 YEARS, FGD PARTICIPANT, KISUMU)

> "For instance the community favours men, like you can find a boy who impregnated a girl but you won't hear that, but a girl who is in school has been impregnated – you will hear a lot, like a girl of someone is very promiscuous and her mother should take her to get contraceptives. And if the girl has an STI she cannot be treated the same way as boys: if it's a boy, he will be treated the same way as other people but if it is a girl she will be told that she does not know how to handle her matters well, like you are so loose to everybody. The community concentrates so much on ladies, any mistake among ladies is a big problem, but when it comes for boys it is like normal." (FEMALE, 23 YEARS, FGD PARTICIPANT, KISUMU)

26. CARE. (2017) *Applying Theory to Practice: CARE's Journey Piloting Social Norms Measures for Gender Programming.*

In FGDs in Siaya and Bungoma Counties, young people shared about norms existing around young women who undergo abortion:

> "If you even try to abort a child you will die, not have children in future or when you get married you will miscarry until the number of abortion has been achieved." (MALE, FGD PARTICIPANT, BUNGOMA)

> "Abortion … it is seen as a sin you have killed someone, and another thing is that they say that those girls who procure abortion carry out prostitution work/sex work because once you are pregnant you cannot go and work." (FEMALE, 18 YEARS, FGD PARTICIPANT, SIAYA)

In most communities where the FGDs took place, young people observed there are cultural and social norms that positively encourage young men to engage in sex. Young people mentioned traditional circumcision as encouraging men who are circumcised to engage in sex as "real men". "Circumcised boys who don't have girlfriends are not real men", one young person said.

While social norms favour or encourage young men engaging in sex activities, on the flipside it was noted that men are not supposed to be seen at health facilities as it portrays weakness. Girls in Kimilili, Bungoma County, discussed how undergoing circumcision in the hospital was considered being weak:

> RESPONDENT 1: To be a strong man, you need not to get circumcised in the hospital but to face a knife in true cultural settings. So many boys used to get infections like STIs, HIV because they were sharing knives
>
> FACILITATOR: And those who are circumcised in the hospitals?
>
> RESPONDENT 2: They are weak – coward boys [laughter]

Men, young people noted, visit the health facilities only when they are very sick:

> "Young men are seen as strong, even just going to the hospital normally means that you are overwhelmed by the illness. So, when you get an STI you get scared to go to the hospital and fear saying that you have the infection." (MALE, FGD PARTICIPANT, KAKAMEGA)

In a few FGDs it was also said that this notion of men needing to be strong inhibited young men who had experienced sexual violence from coming to the clinic:

> RESPONDENT 1: If men are raped they don't come to the facility because they are seen as being strong.
>
> FACILITATOR: Okay…. What else?
>
> RESPONDENT 2: I think it is shameful for a man to come and say I have been raped.

There were also strong attitudes favouring heterosexuality as the norm, making it difficult for young people with other sexual orientations to be accepted. Young people participating in focus group discussions in Kisumu, Nairobi and Siaya Counties said: "Like people believe that a man should be attracted and married to a woman, so there are gays, lesbians … being discriminated against that they are not doing the right thing", and "They are being forced to get out of the community as they are condemned – seen as a curse within the community. They are cursed from their ancestors."

According to young people, some norms were slowly changing for the better. In Bungoma, Nairobi and Homa Bay County FGD participants said that some parents are starting to accept that young people may be sexually active: "Some parents are now coming to terms that their children are having sex, they will even pick up condoms to give their children". In Bungoma County it was mentioned that when young girls got pregnant they used to be chased away from home or forced to stop school, but that now some girls can go back to school and be supported by their parents. Religious norms were seen as slowly changing for the better in Siaya County amongst others, while they were considered "sticky" in Homa Bay: "Some religions have started embracing usage of contraceptives some are encouraging young people to go to the hospitals", and "Religion is a bit tricky – most churches still preach on abstinence."

Healthcare providers' awareness of gender and sexuality-related norms

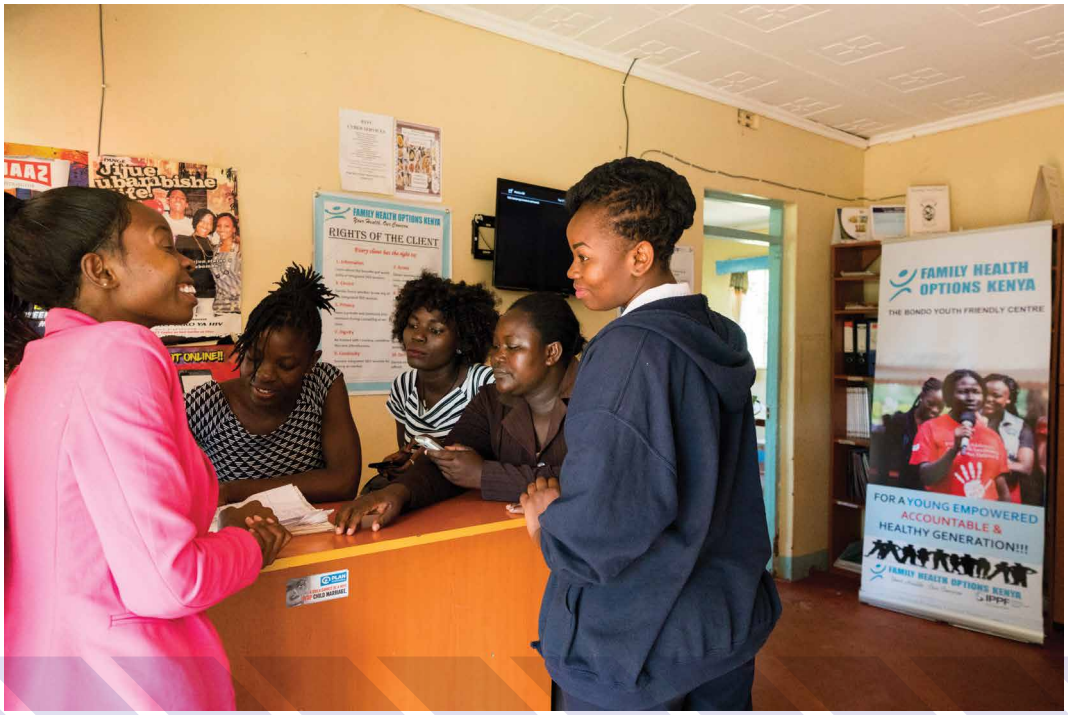
Social norms about sexual abstinence and sexual double standards resonated with beliefs expressed by healthcare providers through the surveys. At the start of the study, 50% of male healthcare providers and 57% of female healthcare providers agreed with the statement "I find it unacceptable for young people to engage in sex". In addition, 40% of male and 21% of female providers agreed with the statement that young men need more sex than young women. Young women who were pregnant and seeking sexual and reproductive health services were seen as 'promiscuous', irresponsible, or lacking respect for the elders:

> "My general view on these young people was that those girls who become pregnant at a tender age are purely irresponsible as well as their parents and they are considered as prostitutes, lack respect for elders and equally lack decent treatment from the community." (FEMALE NURSING OFFICER, KAKAMEGA)

> "For me as a health worker when young people (girls or boys) come in for SRH services and especially when they have an infection and unwanted pregnancies or STIs or even HIV, I think my first impression is that they have been moving around [promiscuous]." (MALE CLINICAL OFFICER, NAIROBI)

Heterosexual norms were also shared by healthcare providers. Seventy percent of male healthcare providers and 85% of female healthcare providers at baseline agreed with the statement, "It disgusts me when I see a man acting like a woman". Also, 50% of male and 46% of female healthcare providers felt that 'real men only have sex with women'. Further, 50% of male and 57% of female healthcare providers reported they would never have a homosexual friend. Finally, 50% of male and 14% of female healthcare providers agreed with the statement that gay men think more about sex than heterosexual men.

Understanding social norms around young people's sexuality is important because it underlines that young people and healthcare providers do not enter the consultation room as blank slates, they bring the above-described norms, values and beliefs with them into the consultation room.



Manifestations of provider bias in the clinic

The social norms described play a strong role in shaping negative provider attitudes and the manifestations of these attitudes inside the health facility. The findings show that these negative attitudes are manifested along a spectrum that includes showing parental or patronising attitudes, discouragement, denial of care or information, and breaching of confidentiality. The following sections describe these manifestations from young people's and healthcare providers' points of view, including the effects it has on care seeking by young people.

Experiences of healthcare providers

During the focus group discussions, healthcare providers spoke about how they sometimes either turned young people away or questioned them on why they engaged in sex, convinced them not to engage in sex while denying them services, or provided them services while denying them information.

> "Okay, for me personally, whenever I saw a young person coming for the contraceptives at the facilities when starting to work as a healthcare provider, it was like a shocker to me. Whenever a young girl comes to the facility to seek contraceptives services, I could not believe - the first question that came to me was how old are you? Why are you not at school? And what are you doing? You are too young to be engaging in any sexual activities. For me, it was like a shock for me." (FEMALE MEDICAL SOCIAL WORKER, NAIROBI)

Healthcare providers admitted that their way of communicating to young people was most comparable to that of a parent or teacher, calling young people to account for their behaviour and for even coming to the facility, acting as if they are in a more informed position than them. Healthcare providers noticed that these parental attitudes offended young people and made them retreat; they observed that their confidence to ask questions about the service was affected negatively. Nevertheless, knowing this did not seem to change how they approached dealing with young people.

Some healthcare providers imposed their own age restrictions on when young people should engage in sexual activity and when they might be capable of making decisions regarding the use of contraceptives.

> "For boys, maybe if they come to the clinic, maybe a 15 year old, and maybe he is asking questions on sex and sexuality it was my feeling that they should still delay ... Maybe 20 years and above because I believe that they will be mature enough in making decisions." (MALE, CLINICAL OFFICER, NAIROBI)

With the conviction that young people cannot make decisions or that they are too young to engage in sex, healthcare providers asked for consent from parents or sexual partners. They would warn young people to delay sex by informing them of the negative outcomes or risks associated with engaging in sexual activities. They also felt uncomfortable discussing SRHR issues with young people, as examples from Nairobi and Kakamega show:

> "I always asked them to ensure they are accompanied by their partners whenever they come to the clinic to seek any services, but if they failed to come with them I would not offer services." (MALE PEER HEALTHCARE PROVIDER, KAKAMEGA AREA)

> "I found myself telling them that it was not right to have sex at their age because sex will expose you to many problems, like HIV and infections." (MALE, CLINICAL OFFICER, NAIROBI)

> "Sexual education and sexual conversations was a no-go zone for me. I still believed that these were not topics to sit and discuss with young people because they were not even supposed to be engaging in sexual activities … Such talks are for adults, and if they sought those services I would request them to be accompanied by their caretakers and parents, therefore, breaching their right to privacy and confidentiality." (FEMALE NURSING OFFICER, KAKAMEGA AREA)

The consent of the parents was very important to healthcare providers, to the point that they would provide a service to a young person at the request of the caregiver with no consideration of the wishes of the right holder. One of the reasons for this was fearing judgment or negative consequences from parents.

> "I had a few restrictions by then in me, especially when I got those young girls coming in for contraceptives … My greatest worry was when I give these contraceptives, especially the hormonal method maybe the side effects, and they have not told their parents, maybe they might have an issue then parents find out that you gave contraceptive to her and the parent comes to confront you." (MALE CLINICAL OFFICER, NAIROBI)

Healthcare providers were sometimes hostile and unwelcoming to young people seeking sexual and reproductive health services and information.

> "The conversations were not friendly at all. I was not gentle to them and I would quarrel and condemn them hence making it difficult to see things from their perspective." (MALE PEER HEALTHCARE PROVIDER, KAKAMEGA AREA)

The different manifestations of provider bias described created unnecessary additional hurdles making it more difficult for young people to access sexual and reproductive health services.

Experiences of young people

Being or feeling judged by healthcare providers because of engaging in sex or using contraceptives stood out in the stories that young people across the six counties shared at the start of the study. These are just a few of the experiences that they described:

> "I went to a clinic when I was 18 years old. The healthcare provider stood up holding her hands on the waist and asked me how old are you? Where is your mother? And asked me why I have started to take up contraceptives. This made me so upset and I felt like standing up and running out of the room." (FEMALE, 19 YEARS, FGD PARTICIPANT, NAIROBI)

> "When I was in form 4 during my last school term, I went to take up HIV testing. The nurse told me you are almost clearing school. Go and study, there is no need for a test. I felt very embarrassed and never took up the test. Since then I have never gone for an HIV test. I just go to the health centre to only take up condoms." (MALE, FGD PARTICIPANT, BUNGOMA)

> "I went to a facility in East Wanga. The healthcare provider saw that I was very young but he judged me and said that I am young and why would I go and take condoms. I was given the condoms in a rude manner but not with any information. I felt bad and did not even take them and I left in a hurry never to go back." (MALE, FGD PARTICIPANT, KAKAMEGA)

Not only actually experiencing unfriendly or judgmental behaviour by healthcare providers, but also anticipating or expecting such behaviour affected how young people sought SRH care. A female respondent from Bungoma County explained: "You will see whether the healthcare provider is friendly first before you start revealing to her your story or problem". One young man from Nairobi even said that because every young person has either heard about or been through a negative experience with a healthcare provider, many young people developed a mindset to expect negative judgment from them. Several young people narrated that instead of "exposing" themselves to negative judgments from healthcare providers they would rather change their story, saying things like, "Judgmental attitude from healthcare providers will make you pretend to be getting a different service than the one you came for", and, "Young people hide the questions they have because unfriendliness of the attitude and facial expression of the healthcare provider".

Expecting or fearing negative judgment from healthcare providers may result in young people not attending or delaying seeking SRHR services. Young people felt this was especially so for girls and for young people of diverse sexual orientations and gender identities. It was said that young people of diverse sexual orientations and gender identities "are scared of being labelled and rejected because of their sexuality, therefore it makes them scared to take up services". For girls, the reasoning was different: while young people described that girls are often attended to faster than boys, the data show that they are also more likely to be treated in an unfriendly manner by healthcare providers, because of different standards for girls' sexuality. This was shared by a female respondent from Nairobi: "The healthcare provider even during childbirth treats you very badly by hitting your legs, tells you I am not the one that made you pregnant … Some girls even abort because they do not want to imagine the pain and pressure and the bad treatment that comes with the childbirth process". Negative experiences with healthcare providers were mentioned as often resulting in young people giving up on SRH services; young people stated that they opted to go to the pharmacies to purchase their contraceptives to avoid the interaction with the healthcare provider.

Some young people mentioned that negative attitudes are less of a concern with young healthcare providers, as one female focus group participant explained, "I would prefer to have youthful healthcare providers who I feel I can relate to better". Young healthcare providers were perceived not to subscribe to social norms. On a positive note, about half of the young people participating in the focus group discussions had been trained under the GUSO programme on sexual and reproductive rights; most of them indicated that knowing they have the right to receive sexual and reproductive health services gave them more confidence when accessing services.

Effects of GTA on healthcare providers' attitudes, beliefs and service provision

This chapter focuses on encouraging indications that, following their GTA training, healthcare providers changed their attitudes on gender and sexuality and, as a consequence, positive changes have been seen in the provision of SRH services to young people.

More appreciation for the SRH rights of young people

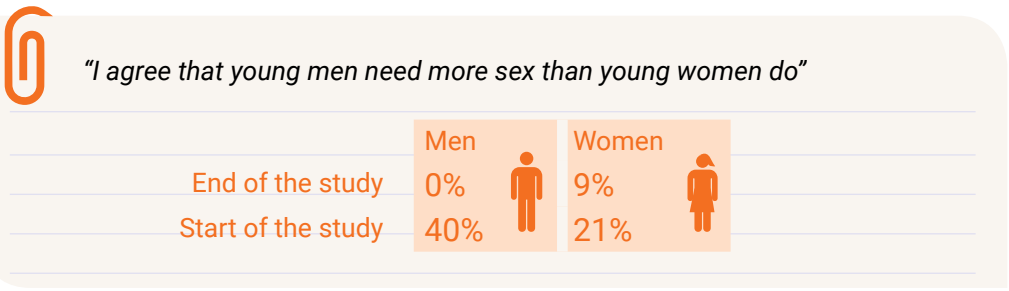
The GTA training included sessions on the rights-based approach, the evolving capacities of young people and the Convention of the Rights of the Child. The aims of these sessions were:

- to raise critical awareness about sexual, reproductive and women's rights in the Kenyan context,
- that trainees would become more open to children having rights and recognise their evolving abilities to make informed choices about their health and wellbeing, and
- that healthcare providers would understand how gender and sexual norms and power relations may intersect with these rights.

Becoming less judgmental towards young people's sexuality

Healthcare providers began a positive change process on the first day of GTA training with an exercise about answering personal questions, tackling topics such as sexuality, relationships and empowerment, to make participants more confident to talk openly and respectfully about sexuality. At the end of the session, one of the lessons drawn by the group was stated, "We shouldn't be judgmental towards youth, as we experienced the same issues when we were young". Other exercises, like the Power Walk where healthcare providers were asked to place themselves in the shoes of a young person, made them more critically aware of gender and power and how it intersects with age, ethnicity and so on. According to the healthcare providers, this made them more empathetic to young people.

This change was reflected in the surveys. At the end of the study, fewer healthcare providers agreed with the statement "I find it unacceptable for young people to engage in sex": 11% of male healthcare providers (against 50% at baseline) and 36% of female healthcare providers agreed (against 57% at baseline). Similarly, at the end of the study, none of the male healthcare providers (against 40% at baseline) and 9% of female healthcare providers (against 21% at baseline) agreed with the statement that young men need more sex than young women do.



Recorded in the diary examples, some healthcare providers had begun to openly tell young people that it was their right to obtain the service they want. As one healthcare provider wrote:

> "I realised he had some fear in coming to the facility, but I encouraged him and informed him that he had a right to visit the health facility ... I realised that these words touched him so much while at the facility. The boy then asked the doctor to let him have an HIV test and he was done very fast."

It appears that this process also reduced the tendency of healthcare providers to view young people who are sexually active, including young HIV positive people, as promiscuous. One male healthcare provider explained: "I have developed a very positive attitude since the GTA training ... Young people who are HIV positive now get access to contraceptives without being judged as they have equal rights as anyone else. I give the same service despite your status." Healthcare providers' attitudes have become less judgmental to young people in general. One female community health volunteer said: "If a young person has an STI we counsel them, unlike before whereby we used to think it is being promiscuous". Similarly, a female nursing officer said: "I have changed my outlook on people. For example, I now know that not every young pregnant girl is a prostitute".

During the exit interviews, many young people confirmed that healthcare providers were being friendly and non-judgmental, saying things like, "She was not judgmental and listened to me" and "when I gave him the reasons of why I stopped using injectable contraceptives he did not judge me or insist that I continue using it". One healthcare provider shared how it remained a challenge that some of his colleagues kept on having what he called "poor attitudes and rude behaviour" in how they handled young people who came to the facility, in spite of him cascading information to them from his GTA training.

Evolving rights of young adolescents in SRHR

At the end of the study, several healthcare providers shared that the session on evolving capacities of young people had impacted them: they now better understood that (young) adolescents have capacity to take responsibility for decisions affecting their sexual and reproductive health.

> "For me I think what helped me more was when we were taken through the SRH rights in-depth, I came to understand that it is their right to access these services. So, when a young person comes to me for a certain service, I understand this young person knows what he/she is doing, he/she has information on what has caused him/her to come to the facility regardless of age. If the 16-year-old girl comes to the clinic for a contraceptive, I am not reluctant to give them so I will just give them whatever he/she wants without fear of the parents." (MALE CLINICAL OFFICER, NAIROBI)

There was a positive transformation reported on provision of services to young people who come to the facility on their own; this also applied to the quite common situation of young people coming to the facility with a parent or guardian who tried to coerce them, e.g. into using contraceptives or undertaking a HIV test. After the training, healthcare providers made efforts to listen to the wishes of the young person involved. A diary entry from a female nurse told the story of a 16-year-old girl who had attempted an unsafe abortion at home. Her caregiver, who was against abortion, found her after the failed attempt and brought her to the facility. The nurse wrote:

> "I enquired from her [caregiver] if she had talked to the girl and if so what decision they had arrived at about the pregnancy. The guardian told me … abortion was out of question: she preferred that the girl carries the pregnancy to term … Having got the mind of the guardian I then sought to hear from the young girl.
>
> "After talking to the girl and hearing from her, I gave her a counsel and all the available options. I told her that her choices were to give birth to the child and then give care to the baby as a mother or give the child for adoption, or get abortion services. In her response the young girl said she chose abortion service since she did not want her peers to know that she was pregnant. I had to get her gestation information before asking her once more to confirm to me the option that she had taken.
>
> "The young girl reaffirmed that her choice was still the abortion service. It was a difficult moment since this was against her guardian's wishes. It was now time to put our heads together, the young girl, the guardian and I, since the comprehensive abortion care services cannot be given without the consent of the parent or guardian."

Another diary entry, written by a female nurse, concerned a 16-year-old girl who had run away from school. Her father found her at her boyfriend's home and wanted to know whether or not his daughter was infected with HIV so that he could use the results to press charges against the boy and his parents. The girl did not want the HIV test. The diary entry narrates how the healthcare provider handled this situation:

> "We requested to talk to the girl on her own so she could give us her side of the story and the father agreed … We asked if she was ready for an HIV test at that time and she refused, she wasn't ready for it at that time because she had gone through a lot and she couldn't handle any other blow that could come in her way just in case it turned out to be positive.
>
> "We respected her decision … I and the HIV counsellor called in the father and explained to him why we didn't perform the test and also shared with him what the girl was going through. We explained the rights the children are entitled to and the implication when these rights are violated. The father agreed to listen to the girl's plan."

The diary entries show how the GTA training capacitated healthcare providers to show more respect for the rights of young adolescents, to the extent that they protected their rights ahead of those of parents or guardians.

Empowering young people seeking SRHR services

A number of sessions and exercises from the GTA training aimed to increase awareness of the power healthcare providers have as duty bearers in consultations with young people and how they can choose either to exercise this power in ways that are disempowering to young people, e.g. denying services, or in ways that empower young people to speak up for their rights, by respecting and protecting their interests and providing them with correct and full information.

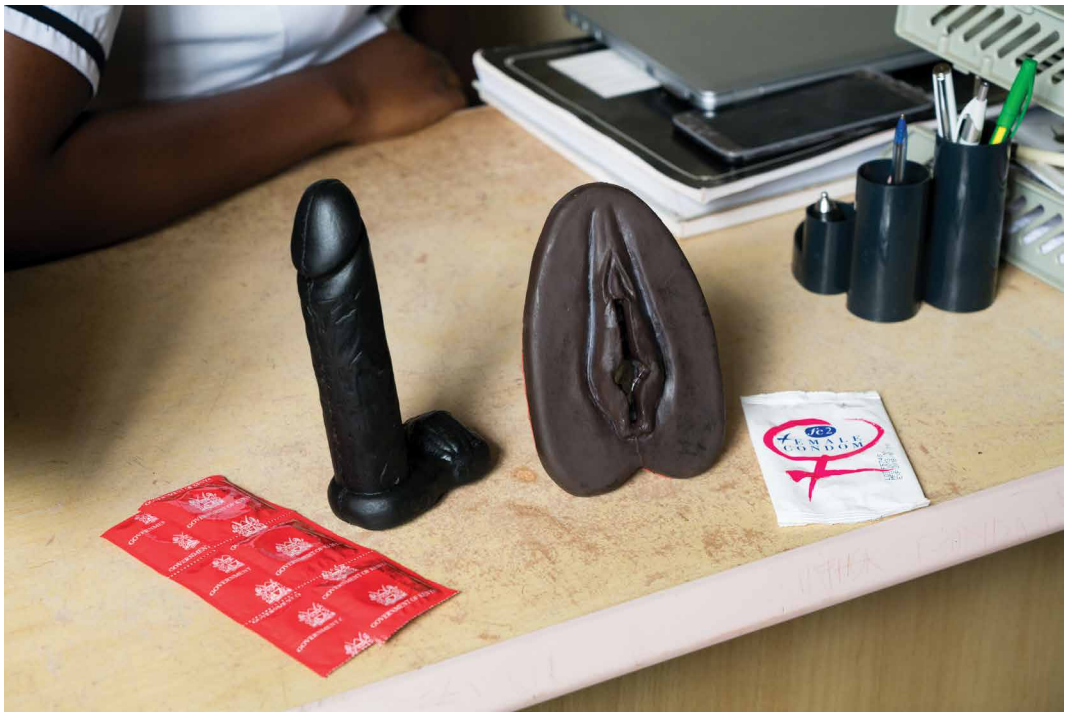
A welcoming and non-judgmental space for young clients

After the GTA training, several healthcare providers expressed that they had begun to listen more attentively to young people and that they could see that this improved their service provision. A male health counsellor explained:

> "I now listen to young people better and give them time to express themselves and understand the challenges they are faced with … There is a change in attitude, for example I would [previously] only attend to people without having much engagement with them, but now I take my time to interact with them and understand them and I give comprehensive care ensuring that I lend them my ear fully. Due to this I have noted that patients now open up about their issues that are affecting them." (MALE HEALTH COUNSELLOR, SIAYA AREA)

In the diaries, healthcare providers also described several instances where a young client arrived just before or after closing time and how they – despite their tiredness and initial inclination to send them away – would attend to them and take their time with them. For example, a female nurse from Kisumu wrote in her diary:

> "A young girl walked in and in my heart I was like 'Why should a client come so late when I'm about to close the day's activities', but I decided to control myself and then settled to serve her because when she just stepped in … a stale air filled



the room and this proved to me that the girl had a serious problem. I made her comfortable on the chair and then asked her how I would assist her but instead of responding she started to cry. I comforted her and reassured her that whichever problem she had, we will try our best to get a solution."

Young people in the exit interviews agreed that they mostly felt welcome, treated in a friendly manner and that healthcare providers had improved their listening skills. They explained this with remarks like, "He treated me very friendly and did not see me as a young person", "The way she handled me was respectful and she took her time to handle my case", and "I was treated with respect, especially when they saw me crying and helped me promptly". Ninety-six percent of the respondents of the client exit interviews were satisfied with the amount of time spent with the healthcare providers. They elaborated upon this by saying things like: "She understood that I did not have enough information and took time to clarify the myths and misconceptions around contraceptives."

Related to this, some healthcare providers mentioned that they had become more observant of whether young people felt comfortable enough to share their SRHR issues openly. If not, they would probe further to get the complete story. This is reflected in the diary case of a 22-year-old male: "At first he raised his complaints suggesting malaria infection, but when I went ahead and probed more I realised he had an STI that was so serious that you could not imagine. I had to examine him and found a number of sores at his genital parts and I really felt sorry for him. He had no money with him, leave alone even the Ksh. 20/= for the purchase of the patient's notebook, and I had to help him."

Several young people shared that they were seen quickly and 90% of young people participating in the client exit interviews were satisfied with the waiting time. One healthcare provider explained one of the main ways in which this is being done: "We are now identifying youths in the queue and attending to them first because they can be shy to be with the other general populations". This was reflected in one of the diaries of a female nurse:

"I spotted this young girl on the queue, she looked tired and shy trying to hide herself behind the mature pregnant women. I decided to serve her first when I called her in the room, made her comfortable and asked her how I could help her. She appreciated this because the women in the queue were talking about her in low tone though she could hear what they were saying: 'This young girl is lining

up with us here and yet she should be in school, girls nowadays go to school to look for men and not to learn'."

These findings suggest that healthcare providers act as duty bearers respecting young people's rights to SRHR services and empowering young people to take up their rights to request contraceptives or other services. This has given young people the confidence to open up, resulting in higher quality of care.

Ensuring privacy and confidentiality

The GTA training made healthcare providers more aware that young people have the right to privacy and confidentiality and that assuring privacy and confidentiality could be particularly powerful when young people were shy or hesitant. These diary excerpts suggest a link between emphasising that privacy and confidentiality would be assured and young people feeling able to open up to share their stories:

"I started counselling him and explained how important it was to get correct treatment. I advised him to be open to the doctor because doctors have taken an oath to keep the patient's sickness a secret … Upon hearing this, he still feared that he would be embarrassed by the doctor if he returned to him, but without giving up I continued counselling. I promised him this was an opportunity to prove that doctors are very good people. They keep people's secrets. Besides it was a chance for the boy to get good treatment and be a mentor to other youths after his success." (FEMALE COMMUNITY HEALTH VOLUNTEER)

"A female of 19 years old comes to the clinic accompanied by her boyfriend … She enters with me in the consultation room, but the boyfriend takes a seat at the reception reading an IEC material. I offer her a seat and tell her to be free, feel at the right place, I will do all I can to assist her and whatever we discuss will be kept between me and her." (MALE CLINICAL OFFICER)

"She felt very shy at first when she wanted to express her problems. I assured her that everything we discuss here will remain between me and her and no third party." (FEMALE COMMUNITY HEALTH VOLUNTEER)

During the exit interviews most respondents indicated that they were happy with the privacy and confidentiality provided to them, saying, "the provider assured confidentiality … I felt respected because I was consulted in a private room", and "At first instance, I was not ready to open up to her, but she was able to bring me around and assured me of confidentiality".

Increased comfort to discuss sexuality with young people

Four of the healthcare providers specifically mentioned how, as an effect of the GTA training, they felt more comfortable in discussing sensitive issues with young people. They explained this as follows:

"People at work mock me now since I speak much of SRH among the youth and yesterday I got a call to speak to the youth and my colleagues complain that I speak to the youth much too freely [laughing]." (FEMALE NURSING OFFICER)

"My attitude has changed since the training and I can now speak freely to them [young people] and give them the information they need, and I help them to make informed decisions." (MALE MENTOR)

"I feel comfortable now to get clients to open up to me." (FEMALE NURSE COUNSELLOR)

"In my facility, the young people would fear me, but now they can talk freely. Sincerely I am proud of myself." (ONE OF THE HEALTHCARE PROVIDERS DURING SECOND GTA TRAINING)

In the exit interviews, several young people explained how the healthcare providers ensured that they were comfortable when being asked questions on sensitive issues and during procedures. In one example, "When he asked me about my relationship, he gave me time and asked me whether I am willing to talk about it or not and each time he asked a question he asked whether I am comfortable or not".

Addressing and transforming harmful gender norms

One of the GTA sessions was on the existing social norms, how they could impede access and provision of sexual and reproductive health services, sometimes with particularly negative effects for young women, and how they could be changed. In their diaries, healthcare providers started to pay attention to social norms and reflected on how they discussed gender and sexuality-related norms with young people, showed understanding of how they affected them and tried to support them in navigating these. The way they addressed such norms was often in hopeful and positive ways, as can be seen from these examples:

Sexual and gender-based violence

"Sarah was a 16-year-old girl working as a house helper who was found on the street, raped and with bruises of the violence she encountered each day in her violent marriage. As a healthcare provider I offered counselling and reported this as a gender-based violence … I also managed to explain to Sarah that women have a right and goal to be empowered unlike the ancient days where men would ask women to be housewives. I created a good rapport with the young girl. I felt for the young girl and I expressed my thoughts as an elder sister not just a healthcare provider. I managed to break the norm that men have a right to beat young women in marriage."

Religion and sexual norms

"We helped out … Abbie, the pastor's daughter … some few weeks back. Today she has come with a friend who is 23 years old, son to the church elder. He had shared with Abbie how sexually active he is and fears that he may get some infections but due to the fact that he is the son to the clergy there is no one he feels safe to talk to. Abbie told him that there is someone he can talk to, so here we are again. Since he is a son of the clergy everyone thinks that he is a virgin waiting for marriage, they assume he doesn't know sex, can't engage in sex, and the parents can't talk about it because it's not a holy topic. Since he is an adult I take him through comprehensive education on sex, sexuality and sexual and reproductive health. After that he tells me that he feels that even Christians are not immune to this and they should be reached with this information. He gives examples of friends he has seen suffer in silence because of these norms that Christians are too holy to engage in such sexual activities and learning. His plan now is to always use the condom as a contraceptive to avoid unplanned pregnancy; he promises to come back on Monday with the girlfriend so that they can learn again together."

The last example is about one of the healthcare workers supporting a 16-year-old married woman who was raped some years before and has suffered in silence from the trauma and a serious STI. The female nurse encouraged the woman to share her experience with her

husband despite norms that prevent women discussing sexual issues openly and assured her that women too have the right to pleasurable sexual experiences.

> "Her past sexual experience has made her not to be free to have sex with her husband. She says that they always struggle for her to accept sexual intercourse … As she narrated to me her story, tears freely flowed down her cheeks. It was an emotional time and I felt quite moved by her feelings. I counselled her and gave encouragement to her and told her that it is important for her to share her past life with her husband for him to understand her and again as a woman she should also enjoy sex but not to be an object … I encouraged her once again to talk to the husband about her feelings because, as a woman, she has a right to sexual satisfaction … It is believed that women do not speak about sex with their partners and if you speak about it then you are promiscuous. I tried to break this harmful gender norm by telling her that she should enjoy sex, and this will happen when they discuss with her partner."

Other diary entries described how healthcare providers encouraged young women and girls who got pregnant to return to school. They also talked to parents about supporting young women to continue with education. There were still a few instances where norms were not positively shifted. Provision of abortion services remained a sensitive topic, with a few healthcare providers feeling "haunted" by their religious beliefs after performing an abortion or opting to refer for abortion services instead of performing one themselves. Finally, in a few instances healthcare providers still tried to convince sexually active young people to abstain, or to carry their pregnancy to term when they sought an abortion, so effectively deciding for the young person.

Engaging adolescent boys and young men

The GTA training had a positive impact on healthcare providers in increasing awareness that young men need to be engaged more in sexual and reproductive health services. They became more aware that young men face their own barriers when it comes to accessing services, e.g. the need to be perceived strong, and that healthcare providers are themselves influenced by those norms and therefore, perhaps unintentionally, pay less attention to SRHR needs of young men. For example:

> "Before … I used to deal with only girls because I thought only girls have SRH problems, but after the training I realised that even boys have SRH problems. So, when we are doing our monthly forums where we get groups of young people and give them information for SRH, I used to tell the Community Health Volunteers to concentrate more on young girls, but now I tell them to have 50% boys and 50% girls." (MALE CLINICAL OFFICER, NAIROBI)

According to one of the healthcare providers from Nairobi, "Initially there was a low number of young male persons coming to pick contraceptives, but nowadays they are free they just come and pick then go." Healthcare providers also made efforts to acknowledge young men for coming to the clinic:

> "I made an effort by encouraging him that it was a wise idea of walking into a health facility and that men also have a right to know their status." (FEMALE NURSE)

Young men confirmed this in the exit interviews: "Our interaction was good because he appreciated me as a young man and that I had taken a good step to come for the services and encouraged me to bring my friends too."

Also, there was a clear shift away from viewing young men as the dominant decision-makers who could make reproductive health decisions for women. Healthcare providers have started to involve young men in decision making with their partners in supportive ways, encouraging equitable gender relations. For example, a female nurse captured the following in her diary about a 19-year-old female who came to the outpatient department feeling unwell and whose husband was not supportive of her contraceptive choice:

"She asks me if [the Jadelle implant] could be the cause of her problems, but before I can answer, the husband interjects and tells her off, that the family planning method is causing her problems and he wants it removed. He claims the wife never asked him for permission before taking the implant. They only have one child and he is afraid the wife may not conceive again because she is not having her periods … and the family planning method has diminished his wife's sexual desires.

"I request him to cool down: I tell him I respect his opinions and ask him to also listen to my opinion as a healthcare worker so that we can reach a consensus. I counsel them on the action and side effects of Jadelle and the advantages of family planning. I inform them it is their right as a couple to decide to have children by choice not by chance, and they should therefore plan on when, and the number of children to have. I advise the husband that his wife is just sick, and her symptoms are not side effects of Jadelle.

"He accepts that; we carry out further investigations and blood tests confirm that Janet has malaria … I assure her that her periods will just come. The husband appreciates and tells me that if I could not have convinced him, he could have ensured the Jadelle is removed. I thank them for listening and responding positively. I reflect and appreciate the skills gained through the GTA training because they left convinced, knowledgeable and transformed against the myths towards family planning."

Attention to sexual diversity in services

For the healthcare providers, important positive changes were seen in their attitudes towards young people with diverse sexual orientations and gender identities over the course of this study. Fifty percent of male and 46% of female healthcare providers felt that "real men only have sex with women" which changed to 22% and 45% at endline. Further, 50% of male and 57% of female healthcare providers reported they would never have a homosexual friend, changing to 22% and 27% percent at endline. Finally, 50% of male and 14% of female healthcare providers agreed with the statement that gay men think more about sex than heterosexual men. This changed to 0% and 18% at endline. Seventy percent of male healthcare providers and 85% of female healthcare providers at baseline agreed with the statement below. This had shifted positively to 11% of male and 36% of female healthcare providers at the end of the study.

These positive changes in attitudes were affirmed by healthcare providers in the focus group discussions. Healthcare providers stated:

"It disgusts me when I see a man acting like a woman"

	Men	Women
End of the study	11%	36%
Start of the study	75%	85%

> "I have changed my perception towards the young people, especially LGBTQ, and I always engage them and offer them services. I am more free in interacting with them." (FEMALE NURSING OFFICER)

> "I feel empowered that I now respect the sexual minorities, see them as human beings, I respect their feelings, champion for their rights." (MALE NURSING OFFICER)

While professional attitudes towards young people from different sexual orientations saw a significant positive shift, at the same time this remained a challenging area for many healthcare providers. One mentioned, "I have some personal beliefs that are more inclined to religion that make it a bit difficult for me to relate to the LGBTQ, especially the men who have sex with men". Another healthcare provider shared that although his personal attitudes towards young people of diverse sexual orientations and gender identity had shifted, it was very challenging to shift the attitudes of co-workers, "Many nurses are still hesitant, they are still saying these issues of LGBTQ are difficult to handle, they need more training to understand these people. And when you ask why it is difficult to help these people they say how do you expect us to attend to these clients when my culture does not allow that". Two healthcare providers described it very clearly, saying that their professional attitudes towards young people of different sexual orientations had changed but that it would take more time or training – or even changed attitudes in the community as a whole – to truly change their personal beliefs: "I still do not know how to handle the sexual minorities groups when I meet them without being worried that I will stigmatise them. I would provide services to them but not want to associate with them," and "Sexual minorities are not accepted in my community, therefore I fear associating with sexual minorities as I would not want to be seen with them".

Lack of awareness and experience

The fact that healthcare providers do not often (knowingly) come across young people with different sexual orientations also seems to play a role. The key informants, for example, said that they encounter few young people with different orientations in their work or do not come across them at all, this perhaps because there are some facilities in Kenya offering targeted SRHR services to young people with different sexual orientations and the young people who know of them may prefer going there. They had the impression that young people would often not disclose their sexual identity during consultations and, in general, healthcare providers and sexual and reproductive health services were not well attuned to the needs of these groups. In the rare case that a young person would be open about their sexual identity, such data would not be captured in health facility records. According to the key informants, healthcare providers – as well as communities – needed more sensitisation to attend to these young people.

Positive strategies in reaching out to young people from different sexual orientations were also mentioned, for example by a female reproductive health coordinator in Kakamega area:

> "We organise moonlight [night-time outreach] services on a monthly basis and there are available healthcare workers who have been trained on how to interact with them, we use snowballing method whereby when we serve one of them we encourage them to invite their peers to come and get services, they also have contact/focal people who understand their needs who support in engaging in getting the service they need."

Key informants also suggested use of peer educators who are trained and knowledgeable on how to handle sexual minorities; that working with peers will help with coming out and

motivate people to seek SRH services. It was suggested that empowering young people of diverse sexual orientations and gender identities to take up the services can improve inclusivity on SRH. From the diaries, it also became clear that some healthcare providers were already providing services and taking up supportive roles to young people with diverse sexual orientations:

"It's 5.32 pm as I am about to lock the door a guy walks in and requests to speak to me. He tells me how he finds it easy to behave more feminine than masculine. The problem now is that the community and peers talk to him like that is not right according to the societal norms, he feels left out and not fit for the community, he says he doesn't have any constant supporting friend but wishes he had a few friends who could be supporting him.

"I begin by telling him that it's normal if that is how he feels to be, I talk to him about other youths I know of that have similar lifestyles. The guy wants to know them to see if they can be friends, so I promise him to come the following day so that he could meet them and see if they can be friends. He smiles showing relief and walks out, I make few calls to reach the guys so that we can plan a meeting after which I leave because it's already late."

The next day this peer provider from Siaya County managed to introduce the client to a group of other youths from different sexual orientations, which ends up going well:

"As the day goes on more youths are coming and they are both joined at the youth centre hall, the guy feels accepted and he is happy sharing his stories to the fellow youths. I look at the way the youths are welcoming him and feel like we are doing great fighting gender norms and stigmatisation".

Increase in the uptake of SRH services by young people

Nearly half of the healthcare providers specifically mentioned that, as a consequence of applying what they had learned in the GTA training, more young people are coming to them or their facility for SRH services.[27] They related this to their understanding the SRH rights and needs of young people better, young people feeling freer to come and seek services, young people referring their peers after being treated well, and young people being treated better at the facility after the healthcare provider cascaded his/her insights from the GTA training, involving schools and teachers as well as having community dialogues and special days in the health facility for adolescents. These are some of the experiences shared by healthcare providers:

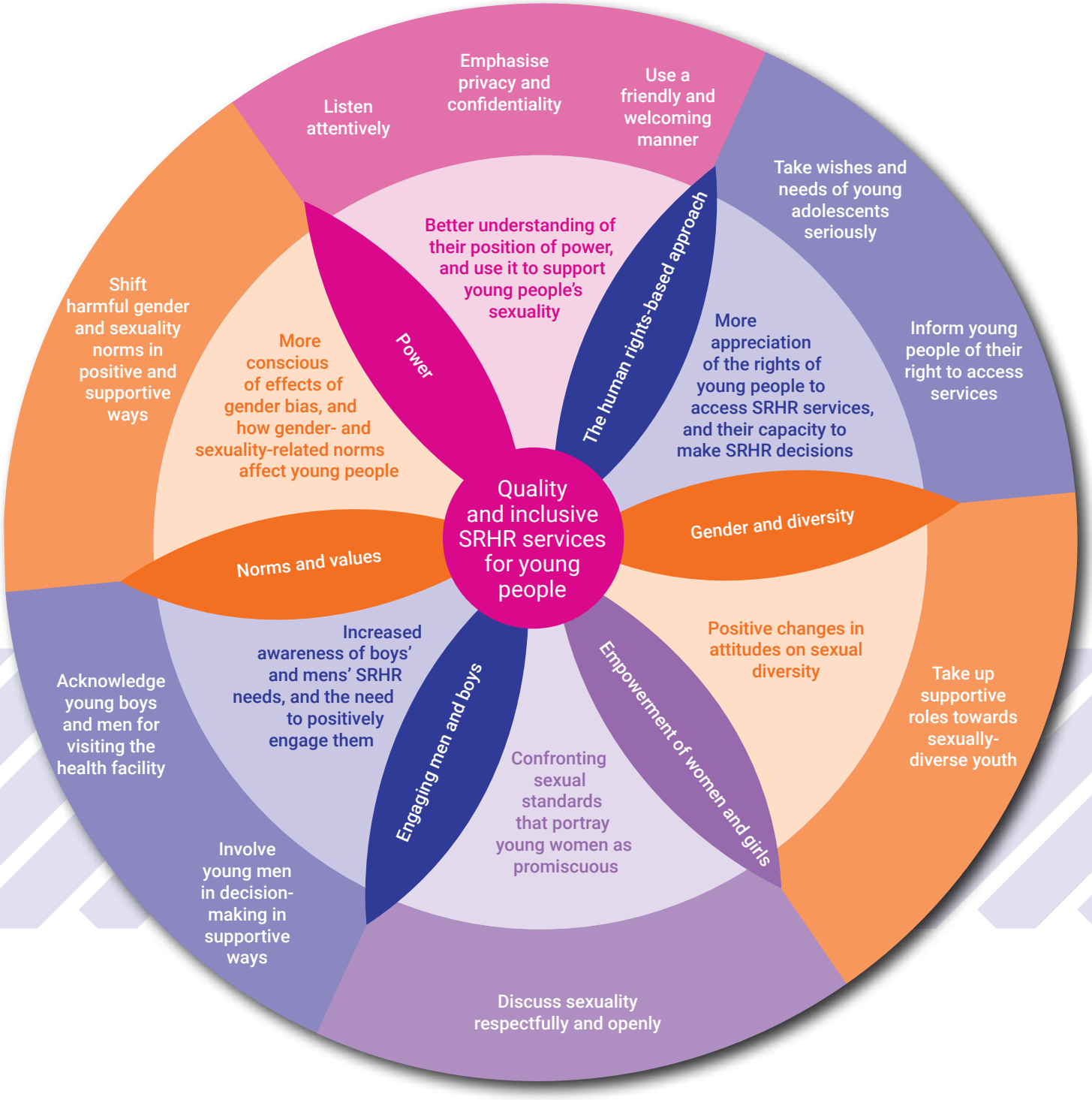
"The number of young people has increased compared to previous times and now cases of unsafe abortion decreased in my facility because now they can feel free to come and get services". (FEMALE NURSE)

"It changed much when I involved the school management and teachers on the issues of SRH and now I see students from the schools I work with visiting the clinic for various reasons … They also now have more information regarding contraceptives and STIs, their treatment and management, and they no longer self-diagnose themselves as it was earlier on." (FEMALE NURSE)

"Nowadays we have selected some days for adolescents. It has really made young people feel free and at home to get services and we have support groups specifically for adolescents". (FEMALE MEDICAL SOCIAL WORKER)

27. Figure 1. visualises the ways in which the Rutgers GTA approach contributes to quality and inclusive SRHR services for young people.

RUTGERS GTA AND YFS FRAMEWORK



Several diary entries also showed how young people specifically asked for that healthcare provider. In the client exit interviews, a few young people also shared that they visited that particular health facility because they were motivated by their peers who had been treated well there, saying things like, "I was motivated by my fellow youths about the good services they offer, the provider is friendly," and "I heard that she (healthcare provider) is secretive, friendly and approachable".

Discussion

This final chapter highlights those elements of this operational research that have been the most and least effective.

Personal change

At a personal level, the quantitative and qualitative findings on gender and sexuality-related attitudes have shown that GTA training enabled healthcare providers to have more empathy for and more acceptance of young people's sexuality, and to reduce beliefs that approved of sexual double standards between young men and women as well as beliefs that favoured male power in contraceptive decision-making. There were also gains in how healthcare providers perceived of diversity in sexual orientation and gender identity, although this change seemed to be more at a professional than a personal level. According to the healthcare providers, these changes were triggered by the knowledge of gender, power and SRH rights that they gained during the GTA training and on the reflexive nature of the sessions and exercises of the training. This made them critically reflect on their own inner feelings and beliefs. This process of reflecting was a key step in their personal change process.

Changed attitudes led to major service improvements

The findings show that healthcare providers' changed attitudes had positive effects on service delivery and made the difference between receiving no care (when young people shy away when feeling judged by a provider) and care that truly responds to young people's needs. On the side of the healthcare providers this required critical reflection on attitudes and behaviour that were part of how they provided services to young people and that may have seemed normal to them before – but seemed less so when interpreted through the GTA. Being attentive or fully listening, being aware of/recognising young people's body language, and actively assuring privacy and confidentiality were among the key changes observed in healthcare providers' service delivery to young people after GTA training. This was crucial in making young people feel respected and comfortable, and making them confident that it was their right to seek services. It gave young people the confidence to open up more about their SRHR issues and the evidence also suggests that it led to more young people coming to the respective facilities because of positive reviews received from their peers.

Activists for young people's SRH rights

The, sometimes fundamental, changes in attitudes facilitated by the GTA training enabled most healthcare providers to become active promoters and defenders of young people's SRH rights. Some healthcare workers became like a lifeline, a listening ear, and a non-judgmental source of vital information to young people. Some became more comfortable discussing issues relating to sexuality with young people, able to give up talking to them with a parental tone or a patronising manner. They continued doing so even when colleagues criticised them for talking too freely to the youth. Others recognised that young people are capable and have the right to make their own, well-informed decisions regarding their sexual and reproductive health, and they protected the decision-making rights of young people versus their caregivers. Realising that beliefs about masculinity had contributed

to fewer young men visiting facilities and to unequal power relations with partners led healthcare providers to engage young men in supportive ways. Finally, some healthcare workers managed to encourage young people by challenging harmful gender and sexuality-related norms during consultations. Norms that were discussed most frequently included encouraging young women that they too have the right to enjoy sex, supporting pregnant girls and young women to continue their education, and challenging norms that certain sexually transmitted infections can only affect women.

Sustainable change but not for some hard-to-change topics

The positive findings were sustained over the five-month period of the study and will hopefully be sustained much longer. When healthcare providers undergo a personal transformation there are opportunities for sustainable change in their professional behaviour if they hold on to this change and view young people through a more positive lens. For some areas, in particular sexual diversity, change turned out to be more difficult at a personal level, although at a professional level highly positive changes were achieved. Provision of abortion and, in a few instances, sexual activity before marriage also remained sensitive topics. For some healthcare providers religious beliefs stood in the way of accepting abortion at the beginning of the study, whilst at the end of the study they still did not fully accept it but were able to refer people to others providing abortion services. In a few instances, healthcare workers were still preaching abstinence. It is important to emphasise that GTA interventions aim to address deeper biases among providers that impact the quality of care for young people, and that such biases may well exist among providers working in ostensibly youth-friendly services aiming to adopt youth-friendly standards of care.[28] Similarly, the pace in which the healthcare providers embraced the Gender Transformative Approach as observed during the training sessions and the quality of their reflections as expressed in their diaries differed. Ideally, to reach a maximum effect, it would have been better to unpack and understand those differences between individual learning trajectories more thoroughly – for example in relation to gender – in order to provide more tailored support over the course of the study.

Self-reflection via diaries

Experiential learning – or "learning through reflection and doing" – is at the core of the Rutgers Gender Transformative Approach and self-reflection is a key element in this. In this study, the diaries were an effective tool for self-reflection. In the diaries, healthcare providers reflected on consultations they held with young people and the impact made, but also critically reflected on what could be done better a next time. Self-reflection was not a skill that came easily to some of the healthcare providers. At the beginning of the study some diary entries seemed more like log entries listing events, leaving out personal emotions or attitudes. Through continual guidance and feedback, personal learning was brought into most of the diaries. In the words of one of the healthcare providers, "Of late, after serving a client, I do lots of self-reflection. I learn and improve on the next client."

More attention needed for creating an enabling environment for gender transformation

This capacity strengthening intervention was directly targeted at healthcare providers who provide SRHR services to young people. Healthcare providers did transmit key GTA messages to communities, mainly through sensitisation and conversations with community leaders. Some of the participants were community health volunteers whose working environments are communities. Positive effects of community sensitisation were also captured in the diaries. However, community sensitisation on GTA was not a key component of this study,

28. Solo, J. & Festin, M. (2019) and Starling, S., Burgess, S., Bennette, N. & Neighbor, H. (2017)

even though it was part of the wider GUSO programme. Healthcare providers mentioned how certain sticky community norms with regards to gender and young people's sexuality were able to persist and that while they received positive feedback in the community, for example parents taking condoms home to make them available to their children if they needed them, other community members – especially parents – resisted their messages. It is important to put more effort into engaging the wider community in understanding and committing to gender transformation. Without attending to gender transformation across different levels of the socio-ecological framework, healthcare providers are implementing GTAs too much in isolation. A GTA is harder to achieve in youth-friendly services if the community is not fully supportive of it.

Recommendations

Based on the findings of this study, the following recommendations are suggested for sustaining the current GTA activities, as well as for future implementation of any new GTA activities in sexual and reproductive health.

National level stakeholders

1. **Engage with the ministry of health, county departments of health and higher education learning institutions in mainstreaming GTA in healthcare provider training**

   To scale up gender transformative approaches in YFS and maximise their effects, there is a need to work with all key stakeholders. GTA should be included in training for healthcare providers in medical training, including nurses, clinicians and medical doctors in addition to those in SRH facilities.

For SRHR CSOs and practitioners

1. **Establish GTA mentors/champions who can follow up with healthcare providers who took GTA training to fulfil a helpdesk/support function**

   Identify healthcare providers who pick up the GTA ideas fast and can mentor others.

2. **Recognise/celebrate some of the good practices of healthcare providers as seen after the GTA intervention to keep them motivated to maintain such practices and to inspire others to follow suit**

   Use channels such as newsletters, social media, blogs, flyers, or any easily accessible channel for practitioners to make positive noise about the good practices of healthcare providers; this will reward healthcare providers for their behaviour while at the same time encourage others to follow suit. Some of the diary entries of healthcare providers in this study were so powerful that they could be translated into a blog or online story.[29]

3. **Stimulate healthcare facilities to have GTA training as part of the inception of new healthcare workers to create better chances for having effects across health facilities as a whole rather than in individual healthcare providers**

   Having GTA training provided to all healthcare providers during their inception period would increase the chances of GTA becoming ingrained in the facility as a whole. This is important because provider bias is also influenced by prevailing norms at the workplace. If these workplace norms mirror dominant social norms it may cause healthcare providers to quickly fall back into previous, negative behaviour. As part of the GTA toolkit, Rutgers developed a module focusing on increasing GTA at an institutional level; facilitators could use this to work with the entire facility to become more gender transformative.[30]

29. For example, some of Zopher's diaries, one presented in the foreword, were partly captured as a photo story on the Rutgers 'Stories of Impact' website: https://stories.rutgers.media/rutgers-showcases/. Another healthcare provider's powerful diaries were noticed by her manager who invited her to present them at an international conference.
30. https://www.rutgers.international/GTA

4. **Put more effort into sensitising the wider community in understanding and committing to gender transformation**

   In this way the interventions (at health facility and community level) can positively reinforce one another; without buy-in from the community it will be more difficult for healthcare providers trained in GTA to sustain positive changes.

5. **Simplify the language around the Gender Transformative Approach and make it a concept that is easy to grasp and work with**

   Not all key informants in the study knew what a GTA was. Within the wider GUSO programme, country alliances also have questions around practical ways of applying the Gender Transformative Approach to sexual and reproductive health interventions. There is an opportunity to develop GTA materials that operationalise the concept, using accessible language to really guide the way to a wider use of gender transformative approaches in sexual and reproductive health programmes.

6. **Use the network of certified GTA master trainers**

   There is a pool of GTA master trainers available. They can offer quality training in the exercises from the GTA modules and also adapt exercises to the local context. They are profiled online on the Trainers Lab.[31] Trainers Lab offers an international marketplace for sexual and reproductive health trainers; the majority of GTA master trainers have placed their profiles on Trainers Lab and can be contacted directly via this website.

7. **Ensure that GTA training emphasises the importance of reflection on actions and includes simple exercises to practise this**

   Experiential learning is key to the Gender Transformative Approach and reflection is a key step in this process. It makes healthcare providers conscious of their own attitudes towards young people's sexuality. Diary writing – as used in this study – is a traditional strategy used for personal learning, but can be time-consuming. Instead, shorter reflection exercises, for example "three key questions" to answer once or twice per week after providing services to a young person, could be built into service provision in a systematic manner.

Future GTA research

1. The Gender Transformative Approach has the potential to realise changes in attitudes and norms in a sustainable way. There is an opportunity to measure long-term intervention effectiveness as well as to test out tools that measure implicit and explicit provider bias.

2. Ethnographic studies should be conducted to create a more in-depth understanding of social norms, both supportive and inhibitive ones, and their role in influencing the attitudes and behaviour of healthcare providers.

3. Similar studies should be set up to increase the emerging evidence on the effectiveness of GTA in minimising certain types of provider bias. This would help to build a convincing case for integrating GTA modules or exercises into curriculums or training for healthcare providers, as well as other service providers such as sexuality education facilitators.

31. Trainers Lab: https://www.trainerslab.net/

Recommendations for youth-friendly service providers and facilities made by young people

Young people involved in the study were asked what could be improved in provision of sexual and reproductive health services to them. The issues brought up most often by these young people were:

1. Healthcare providers should receive training on providing services to young people in a friendly and non-judgmental way.
2. The number of youth-friendly clinics/corners should be increased.
3. The types of services available in youth-friendly services should be expanded so that there is less need to refer young people and they can get everything they need in one place.
4. The working hours of youth-friendly services should include weekends and evenings.
5. Always have a suggestion box so that young people can share and give feedback on the services that are given to them; create youth involvement forums.
6. Healthcare providers should close the doors during consultations to maintain privacy and to make you feel that anything you say is confidential.
7. Healthcare providers should sensitise the community about diverse sexual orientations and gender identities so that these are not stigmatised and their confidence is built.
8. Healthcare providers should create more awareness in the community about young people's SRHR issues; this would also create more demand.
9. Every facility should ensure there are enough male and female youth-friendly healthcare providers/youth mentors so that young people can choose whether they prefer to seek services from a male or female.
10. There is a need to make SRHR services more attractive and welcoming for boys; this will make them more likely to come and seek a service when they need one.
11. Healthcare providers should be patient with young people who come to access services and take time with them until they feel comfortable to open up about their needs.
12. Healthcare providers should make youth-friendly services more welcoming for young people with diverse sexual orientations by creating easy access to services for them through in-reaches, e.g. door-to-door, and outreaches, e.g. community outreach, treating them equally like everybody else, sensitising healthcare providers on how to address them, tailoring information to them, and running positive campaigns using young people with diverse sexual orientations and gender identities as role-models.

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Annexe 1: Timeline of data

Study activity	Study timing	Dates
1. Baseline activities with HCPs • HCP recruitment • GTA training for HCPs, 3 days • Self-administered survey	Survey was administered at the start of the GTA training that was facilitated by GTA master trainers	May 2019
2. Baseline activities with young people • Focus group discussions	Conducted at facilities served by the HCPs immediately following the GTA training	May 2019
3. Ongoing activity with HCPs • Bi-weekly diary writing	Diary writing was conducted every two weeks for a period of five months with frequent feedback by researchers	May – October 2019
4. Midterm activities with HCPs • 1.5-day follow-up GTA training	Conducted approximately 2.5 months after the initial training	30 and 31 July 2019
5. Endline activities with HCPs • Self-administered survey • Focus group discussions	Conducted at facilities served by HCPs	September 2019
6. Endline activities with young people • Client exit interviews	Conducted at facilities served by the HCPs, covering all facilities involved	September 2019

Annexe 2: Training content

Title of session	Educational techniques	Intended learning outcomes
Initial 3-day training		
1. Talking Values	Carousel game, participants sit in two circles of chairs and together discuss answers to carefully selected questions about different aspects of sexuality that are written on cards	Exchange ideas and opinions about SRHR and gender equality; exercise how to talk openly and respectfully about SRHR and sexuality
2. The Rights-Based Approach	Group work, work with handouts, PPTs, reflection and discussion	Participants have critical awareness about sexual, reproductive and women's rights in their particular context. Inventory of the participants' ideas and knowledge about sexual, reproductive and women's rights
3. The Gender Box	Individual, group and plenary reflection and discussion, creation of 'The men box' and 'The women box' with ideas about what it means to be a 'good man' or a 'good woman' in your society	Generate critical (self-)reflection of the participants' own and general gender/sexual beliefs/values and norms in Kenyan society. Generate understanding on how masculinity and femininity are connected to power and inequality Create openness and reflection about this
4. The Power Walk	Interactive group role play, by imagining to be a specific character in a community, participants reflect on gender equality and differences in access to SRHR services, plenary discussion	Participants are aware of the relationship between gender, power, sexual orientation, age, ethnicity, class, caste, race etc. and how these factors reinforce each other to exacerbate (gender) inequalities Participants define what they would and could do to address gender inequalities
5. Norms and Stigma	PPT presentation, group discussion, interactive group participation, work in pairs, silent reflection and sharing in plenary	Participants understand stigma and discrimination in relation to women/girls and people with diverse sexual orientations and gender identities Participants are aware about their own biases in the way they deliver HC
6. Gender-Exploitative, Neutral or Transformative IEC Materials	PPT, review of existing IEC materials, reflection, discussion and planning	Participants develop a critical attitude towards existing and new education materials used in their practice regarding their gender transformative content Openness is created to reflect on unconscious harmful gender messages

Title of session	Educational techniques	Intended learning outcomes
7. Walking Away Transformed	Use of case studies, group work, plenary discussion	Participants have enhanced empathy for young people seeking SRH services and the gendered barriers they must overcome Participants have deepened knowledge of what a GTA to the delivery of YFS entails
8. Evolving Capacities and the Convention of the Rights of the Child	PPT presentation, group work, plenary discussion.	Participants understand the concept of evolving capacities and how gender and sexual norms and power relations might intersect with it Participants become more open to children having rights and evolving abilities to make informed choices about their health and wellbeing
9. Potential of Services to Transform Gender Norms	Plenary discussion, group work with questionnaire, prioritisation	HCW have individual action plan to transform gender norms in the provision of gender transformative YFS
Second GTA training		
10. Recap of Previous Workshop **Sharing on the Application of GTA**	Discussion on changes since the last training, the key GTA issues implemented	Group discussion and reflection to check on progress
11. Existing Norms and Values Related to YFS	Brainstorming about and sharing personal experiences of the positive and negative norms related to access and provision of YFS and how they have been managing them	Provide skills to identify (positive and negative) norms related to YFS provision and reflect on if they should re-structure and work on some of these norms
12. YFS Ideal Transformative Conversations	In groups, participants put themselves in the shoes of a young person, reflect on the 6 principles of GTA and come up with one dilemma that a young person would bring to a service provider; the groups each enact their role plays to other participants and feedback is provided	Session is aimed at identifying good examples of interactions in YFS demonstrating a gender transformative approach and finding solutions to enhancing the capacity of YFS service providers where a GTA is not taken

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