Rutgers

For sexual and reproductive health and rights

Building the capacity of healthcare providers in the Gender Transformative Approach to improve the SRHR of young people in Kenya

EVIDENCE BRIEF

When young people seek a sexual and reproductive health (SRH) service they have to meet a healthcare provider. The attitudes of health professionals are therefore critical to young people exercising their right to access SRH services.

The World Health Organization and others describe youth-friendly sexual and reproductive health services as based on principles like confidentiality, non-judgmental and respectful care. Unfortunately, the reality is that young people and adolescents aren't always well received in health facilities, often encountering providers who are judgmental, treat them rudely, or even deny them services. Healthcare providers' negative attitudes – or "provider bias" – are a real barrier to young people's access to good quality sexual and reproductive healthcare.

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

FEMALE NURSE WRITING IN HER DIARY AFTER APPLYING HER GTA TRAINING

In 2019, we tested the effectiveness of training service providers on gender transformative approaches by working with healthcare providers and users of "youth-friendly" SRH services in Kenya over a five-month period. Gender transformative approaches recognise the negative impacts of some sexual and gender attitudes – or norms – and try to address them. These norms can bring negative attitudes about young people and sex into the clinic. We know that changing these attitudes and norms can be effective in improving service provision, but there is a gap in evidence on what interventions are effective at making those changes.

This study showed that attitudes rooted in long-established ideas about gender roles, age-appropriate behaviour, the morality of same-sex relationships and so on, can be transformed through GTA training and encouraging self-reflection. As a result, we saw improvements in the quality and inclusiveness of sexual and reproductive health services to young people, especially women and girls and young people with diverse sexual orientations and gender identities.

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Rutgers has developed an innovative toolkit for implementing its Gender Transformative Approach in sexual and reproductive health and rights programmes. For the study, 24 healthcare providers who worked in SRH services that were supposed to be youth friendly were trained using *Module 3: Gender transformative approach and youth-friendly services* of the Rutgers GTA Toolkit. Participants reflected on their current sexual and gender attitudes at the start of the study and the way they dealt with young people seeking to access their services. Then they participated in two intensive training sessions covering different aspects of GTA. Their gender attitudes were recorded in surveys at the beginning and end of the five months. And throughout the study, participants recorded their encounters with young people at work in diaries, encouraging deeper reflection on the way they dealt with them and whether this changed.

To provide the young people's perspective, responses from over 100 young service users on their experiences of dealing with SRH providers were collected through focus group discussions and exit interviews.

Key findings

It was clear that gender and sexuality-related norms can have negative effects on young people's experience of SRH services. At the start of the study, the most common obstacle to young people accessing SRH 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. Before the GTA training, 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 about sexual diversity, particularly male homosexuality.

These attitudes resulted in different types of negative behaviour from providers, ranging from patronising attitudes to denial of services and breaching of confidentiality and privacy. Their increased knowledge on gender and power from the GTA training and the reflective process of keeping diaries and discussing them with researchers enabled healthcare providers to reflect critically on their own personal attitudes. This had positive effects on how they interacted with young people coming to their clinics. The key changes observed in the healthcare providers were:

- increased skills in making young people comfortable (through attentive listening and reassuring them about 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 gender and sexuality-related 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 facilities we studied.

Conclusion

The study provided evidence that GTA training can lead to sustained changes in healthcare providers' gender and sexuality-related attitudes, transforming them into more positive ones. These changes quickly led to improvements in the quality and inclusiveness of sexual and reproductive health services for young people. It also showed that self-reflection (the diary writing in this case), is a powerful tool for triggering changes in attitudes. The study has succeeded in contributing to the emerging evidence on what interventions work to minimise provider bias.

Recommendations

Key recommendations emerged for sustaining current GTA activities and for new GTA activities in SRHR, including:

1. Engage at ministry and county levels to mainstream GTA in healthcare provider training
2. Expand GTA training to cover more healthcare staff, in and out of SRH services
3. Celebrate some of the good practices adopted by healthcare providers after the GTA training, to motivate and inspire
4. Simplify language around the GTA, making it easier to grasp and work with
5. Ensure that GTA training emphasises the importance of reflection on actions and includes simple exercises to practice this
6. Healthcare providers should sensitise the community to young people's SRHR issues including sexual diversity
7. Facilities should have male and female youth-friendly healthcare providers so young people can choose
8. Make SRHR services more attractive and welcoming for adolescent boys and young men

Visit www.rutgers.international/GTA for the full report and the Rutgers GTA Toolkit