ORIGINAL RESEARCH ARTICLE

Applying community-based action learning in the provision of gender-transformative sexual and reproductive health services in Ebonyi State, Nigeria

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Abstract

This study describes the adoption of an action learning (AL) approach to (i) identify challenges that primary healthcare workers face in delivering gender-transformative sexual and reproductive health and rights (SRHR) services to young people, and (ii) recommend feasible solutions to resolve these challenges. This study implemented in Ebonyi State, Nigeria, included three AL structured sessions with healthcare workers, community members, and researchers. AL participants formed six groups, each representing one of the six selected local government areas. Data on potential challenges in providing youth-friendly gender-equitable and inclusive SRHR services and strategies for addressing them were synthesized through consultations with the stakeholders using the modified Delphi technique. The key challenges that health workers faced were: (i) provider-related issues such as personal values and beliefs regarding providing contraceptives to young unmarried people; (ii) community/client-related issues such as lack of male, parents/guardians, and community support; and (iii) negative perceptions regarding health seeking for SRHR services. Proposed strategies include reaching young men and boys with SRHR services outside Primary Health Care settings; facilitating dialogue to support female partners; and promoting community advocacy. AL has shown promise in understanding young people's SRHR challenges and in developing strategies to advance gender-transformative youth-friendly SRHR services in Nigeria. *(Afr J Reprod Health 2025; 29 [6s]: 89-105).*

Keywords: Action learning, SRHR, young people, gender transformative approach

Résumé

Français Cette étude décrit l'adoption d'une approche d'apprentissage par l'action (AL) pour (i) identifier les défis auxquels sont confrontés les agents de santé primaires dans la prestation de services de santé et de droits sexuels et reproductifs (SDSR) transformateurs de genre aux jeunes, et (ii) recommander des solutions réalisables pour résoudre ces défis. Cette étude mise en œuvre dans l'État d'Ebonyi, au Nigéria, comprenait trois sessions structurées d'AL avec des agents de santé, des membres de la communauté et des chercheurs. Les participants à l'AL ont formé six groupes, chacun représentant l'une des six zones de gouvernement local sélectionnées. Les données sur les défis potentiels liés à la fourniture de services de SDSR adaptés aux jeunes, équitables et inclusifs en matière de genre, ainsi que les stratégies pour y remédier, ont été synthétisées lors de consultations avec les parties prenantes à l'aide de la technique Delphi modifiée. Les principaux défis auxquels les agents de santé ont été confrontés étaient : (i) les problèmes liés aux prestataires, tels que les valeurs et les croyances personnelles concernant la fourniture de contraceptifs aux jeunes célibataires ; (ii) les problèmes liés à la communauté/aux clients, tels que le manque de soutien des hommes, des parents/tuteurs et de la communauté ; et (iii) les perceptions négatives concernant la recherche de services de SDSR. Les stratégies proposées comprennent l'accès des jeunes hommes et des garçons aux services de SDSR en dehors des établissements de soins de santé primaires ; la facilitation du dialogue pour soutenir les partenaires féminines ; et promouvoir le plaidoyer communautaire. AL s'est révélé prometteur dans la compréhension des défis des jeunes en matière de SDSR et dans l'élaboration de stratégies visant à promouvoir des services de SDSR adaptés aux jeunes et transformatifs en matière de genre au Nigéria. *(Afr J Reprod Health 2025; 29 [6s]: 89-105).*

Mots-clés: Apprentissage par l'action, SDSR, jeunes, approche transformatrice en matière de genre

Introduction

Globally, youth-friendly sexual and reproductive health and rights (SRHR) services are designed to provide accessible, acceptable, and equitable healthcare tailored to young people's needs [1]. These services typically include comprehensive sexuality education, confidential counselling, access to contraceptives, and other services. However, in sub-Saharan Africa, including Nigeria, young people face significant barriers in accessing these services[2,3]. These challenges include limited access to SRHR information, unfriendly attitudes of healthcare providers, concerns about confidentiality, experiences of embarrassment, and restrictive gender norms[4-7]. These obstacles lead to risky sexual behaviours, resulting in high rates of sexually transmitted infections (STIs) and HIV, early pregnancies, and complications during delivery[2,8]. Gender and social norms further exacerbate these issues, perpetuating inequities and limiting young people's access to SRHR services.

In Ebonyi State, south-east Nigeria, efforts have been made to address the SRHR needs of young people[9] but persistent unequal gender and social norms among community members and healthcare providers continue to limit their access to these services[5,10]. The situation is particularly challenging for young women and girls, who bear the brunt of gender inequalities[6,10]. To effectively address these issues, gender transformative approaches (GTA) are essential for creating an environment where people can access and benefit from SRHR information and services without discrimination or fear[11,12]. GTA has the potential to address unequal gender norms and power dynamics that hinder young people's access to SRHR services. However, while there has been growing investment in GTA, and a few programs documented[13,14], the evidence of their effectiveness in addressing young people's access and utilization of SRHR services remains unclear[15,16].

Action learning (AL) is a practical method that is effective in healthcare settings for empowering healthcare workers (HCWs) and enhancing their problem-solving and critical-thinking abilities[17,18]. The application of an action-learning approach to support an intervention that builds HCWs' capacity to apply a gender transformative approach to youth-friendly SRHR services can help to address and shift existing gender norms and power dynamics. Action learning is a process where a small group works on real problems, taking action, and learning as individuals, as a team, and as an organization[19]. This can be effective in dynamic and complex settings. AL emphasizes collaborative reflection, encouraging critical thinking, adaptability, and continuous improvement for sustainable changes[17,18], making it a useful approach for developing gender-transformative SRHR strategies.

This study is part of a larger project that aims to stimulate individual and organizational change in youth-friendly SRHR service delivery by implementing a multi-component intervention that will contribute to the delivery of quality and inclusive SRHR services for young people. To achieve this, an action learning initiative was designed for deployment within Local Government Areas (LGAs), with each LGA forming a distinct action learning group.

This paper addresses a critical gap in youth-friendly SRHR services by showcasing the use of an AL approach to develop gender-transformative strategies in Ebonyi State. Led by the Health Policy Research Group at the University of Nigeria, the intervention leverages AL to encourage reflective practices among healthcare workers and community members, helping them to recognize and address their gender biases. By tackling both community- and provider-side barriers, the intervention aimed to create actionable strategies that challenge harmful norms limiting young people from accessing SRHR services. This study describes the process of designing an AL approach and its outcomes, providing valuable evidence to inform more effective, gender-sensitive SRHR programming for this population.

Methods

Study area

Ebonyi State, one of Nigeria's 36 federating states in the southeastern part of the country, is noted for its significant rates of teenage pregnancies and the substantial demand for contraceptives among its youth[20]. The state has an estimated population of approximately 4 million residents[21]. Among them, over 500,000 are aged 10–19 years, while about 366,000 fall within the age range of 20–29 years[22]. For governance, Ebonyi State is segmented into

three senatorial districts and encompasses 13 Local Government Areas (LGAs).

Ebonyi State faces a significant challenge with high rates of teenage pregnancies and an unmet need for contraceptives among its youth[20]. The maternal mortality rate among adolescent girls aged 15-19 years is alarmingly high at 30.5%[20]. Although there have been efforts to build the capacity of both formal and informal healthcare providers to deliver comprehensive SRHR services[9,23], gender biases among these providers influence their attitudes towards offering these services to young people in the state[25,25].

Co-design of the action learning approach

The initial phase of the study focused on the collaborative development of the action learning approach by the research team and key stakeholders including frontline healthcare managers, partners, and community members. Representatives were from i) the State Ministry of Health, ii) the State Primary Healthcare Development Agency, iii) the Ministry of Women Affairs, iv) the Ministry of Youth, Sports, and Social Development, v) the Primary Healthcare (PHC) facility coordinators at the local government level; and vi) community members including young people. Additionally, partners such as the United Nations Population Fund (UNFPA), United States Agency for International Development (USAID) Integrated Health Program; Youth advocates, and Civil society organizations (CSO) contributed to the design of the AL approach but did not participate in its subsequent implementation. The stakeholders were purposively selected for their significant roles, influence, or vested interest in enhancing the SRHR of young people in Ebonyi State.

Before co-designing the action learning approach, an initial project meeting was held with some stakeholders to identify relevant organisations/ offices and individuals to engage in the project. Stakeholders were mapped based on their power and interest in the field of gender, and SRHR of young people in the state, LGA and community. Following this mapping, a situational analysis was conducted using both quantitative and qualitative research methods. The findings from the situation analysis were presented and discussed with stakeholders in a validation workshop, leading to the co-design of the AL approach. The steps undertaken to design the action-learning approach are presented in Figure 1.

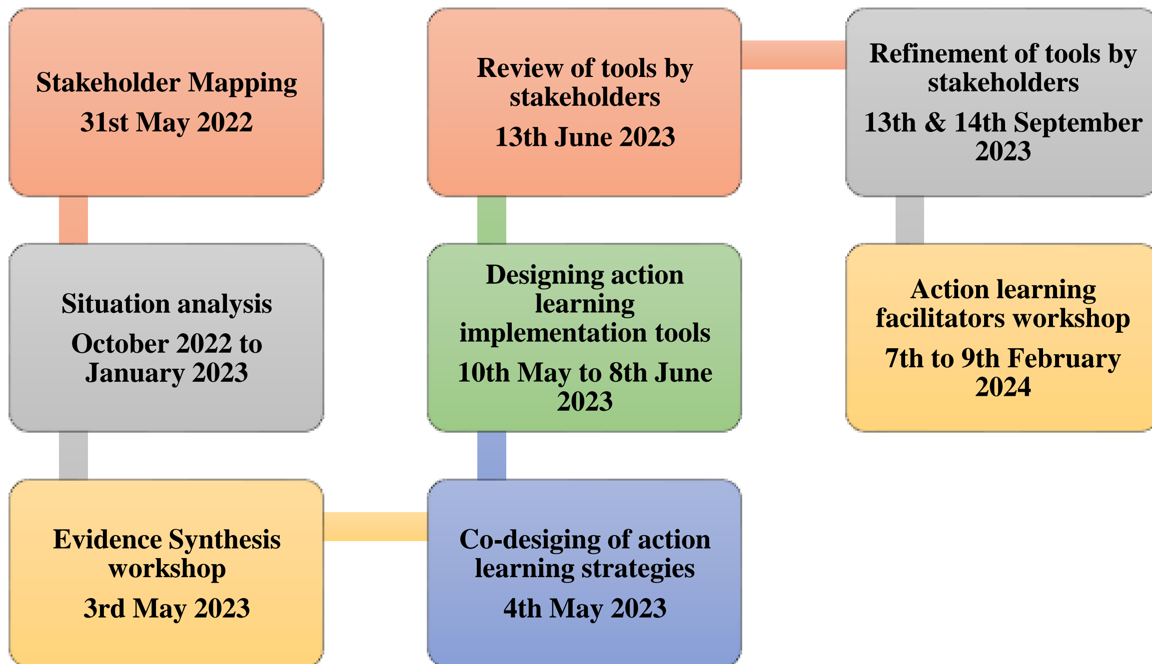

Figure 1: Steps taken to design the action learning approach

Table 1: Gender distribution of collaborators in the action learning intervention co-design

Categories of Participants	Ist workshop held -4th May		2nd workshop held -13th June	
	Female	**Male**	**Female**	**Male**
State level stakeholders	6	6	6	5
Local government PHC coordinators	1	1	1	1
Implementing partners/CSO	3	5	3	4
Community representatives	1	4	1	4
Frontline healthcare workers	0	3	0	3
Young people/advocates	2	1	2	0
Researchers	5	2	5	1
Administrative officer	1	0	1	0
Total	19	22	19	18

Subsequently, two workshops were held with the stakeholders to codesign the approach for delivering action learning sessions in the communities. This AL approach was operationalized, and materials/tools needed for implementing the AL meetings were collaboratively designed. Out of 35 stakeholders that were invited to the workshop, a total of 33 stakeholders attended the first workshop. In addition, 7 academic researchers, and an accountant from the research organization participated in the first workshop. Participants for the first workshop held on 4th May 2023 included six male and six female state program managers, two PHC coordinators, 10 partners/CSO/youth advocates, three healthcare workers, and five community representatives (one female leader, one male youth leader, one male traditional ruler, and two Ward Development Committee (WDC) representatives). The gender distribution of stakeholders who participated in workshops is presented in Table 1.

In the first workshop, group activities were conducted using a brainstorming approach designed to facilitate decision-making without exerting undue pressure on the participants. This approach fostered creative thinking, quickly generated a variety of ideas, and promoted the enthusiastic participation of the group members[26]. Stakeholders were taken on a session about operationalizing implementation strategies based on the Proctor *et al* framework[27]. The framework provides guidance on operationalizing implementation strategies by specifying actors to include, the action, action target, temporality, dose and implementation outcomes. Stakeholders were guided on how to use the Proctor et al framework to operationalize intervention strategies[27]. This was done in groups with each group having a researcher to guide the brainstorming sessions. Each group discussed and agreed on how the AL approach will be operationalized.

Following each brainstorming session, a plenary session took place, which served as a platform for the various groups to present their ideas and offer feedback to the entire workshop attendees. After the brainstorming activities, the research team consolidated the input from all groups and the operationalized sessions were independently ranked to minimize power influences during the group sessions. Each session was rated on a high, medium, or low priority scale, corresponding to scores of 3, 2, and 1, respectively. The outcomes of the individual ranking were shared in a plenary session to ensure that the AL approaches were contextualized before the final list was produced.

This workshop led to the development of an operationalized plan for implementing the action learning process. This includes details on AL meeting frequency, the assignment of unique names for each AL meeting, identification of actors and step-by-step actions for implementation of the AL approach. Subsequently, five stakeholders from the state and zonal levels collaborated with the researchers to design the first draft of the protocol for an integrated AL approach.

All stakeholders who participated in the first workshop were invited to participate in the second workshop, which was held on the 13th of June 2023. However, 30 stakeholders were able to participate in the second workshop as shown in Table 1. In this workshop, the stakeholders reviewed the action learning protocol and identified relevant tools such as a poster, handbills and reflective diaries. They worked in three groups to revise the AL protocol

and agree on the content and design of other identified tools. The protocol contains several sections, including; background; components of action learning; step-by-step action plan to engage healthcare providers and community members in initial and subsequent meetings; AL evaluation, and an introduction to the reflection diary. This introduction to the reflection diary includes details on the target audience, delivery method, models for reflective writing, important factors to guide reflections, and challenges in diary writing.

Implementation of action learning

The implementation was organized into six groups based on location, each representing one of the six LGAs (Abakiliki, Afikpo-south, Ezza-south, Ikwo, Izzi, and Ohaozara). To establish the AL process, the collaborative team leveraged the ideas of Cho and Egan, and the Asia Business School to codesign the intervention [28,29]. Three types of meetings were held: initiation, deployment/implementation, and status update meetings, and each was audio-recorded with the permission of the participants. The action learning meetings were held for seven months, between February and August 2024.

Initiation meeting

The AL initiation meeting at the LGA included two sessions: one for healthcare workers (HCWs) and another for community members. Facilitators, including academic researchers and boundary partners, introduced AL concepts and processes to HCWs. The healthcare service managers who were part of the co-creation team and had undergone GTA training were purposively selected to participate in a four-day intensive AL training for facilitators. These managers, referred to as boundary partners, were paired with researchers to facilitate the AL processes within each group. The initiation meeting session for HCWs was organized to refresh their knowledge of the GTA and to introduce them to journal/diary keeping. Community members were provided with the overview of the GTA SRHR project, focusing on six GTA principles: norms, power, gender, diversity, sexual rights, women and girls empowerment, and engagement of men and boys[30]. Both groups learned about AL processes and the Management Sciences for Health's Challenge model. This model was used to create a shared vision and select priority actions.

Deployment/implementation meeting

The deployment meeting was conducted four weeks after the initiation meeting within the respective AL groups. The meeting also included two sessions: one for healthcare workers (HCWs) and the other for community members. During the session, a modified Delphi technique was used to identify common problems or challenges in providing gender-equitable and inclusive SRHR services to young people. This process is a structured method of developing consensus among group members[31]. Each HCW silently identified three to five common challenges, which were collated, and synthesized. Facilitators presented the comprehensive list, and the HCWs prioritized a challenge that needs to be addressed in their LGA/ communities. This challenge was selected based on its impact on young people's SRHR access and use, as well as the feasibility of addressing it at both facility and community levels. In the deployment meeting session with community members, the prioritized challenges were discussed to ensure they reflected community issues. A consensus was then reached to ensure the feasibility of addressing those challenges, and priority actions were established.

Status update meetings

The status update meetings comprised meetings with healthcare workers, community members and academic researchers. These were follow-up meetings to discuss the implementation of agreed actions and were held twice. During the group meetings, HCWs also reflected on their documented experiences while facilitators noted important points. A recap of the previous meeting was done, and the milestones reached were discussed. The HCWs and community members were encouraged to continue implementing agreed actions. Challenges were addressed through the WhatsApp groups. After the second status update meetings, diaries were submitted for close review and aggregation of contents.

Data description

The data presented in this study is derived from the outputs of the AL deployment meeting sessions. With participants' consent, each session was audio-recorded to ensure accurate documentation. During the meeting, participants were tasked with

identifying common challenges faced by young people in accessing gender-equitable and inclusive SRHR services. Through a process of ranking and consensus building within each AL meeting group, a priority challenge was identified. This approach was used to ensure balanced participation and minimize the influence of dominant community members and healthcare workers.

Following the identification of the priority challenge, participants engaged in discussions to explain the reasons behind their agreement on the challenge they prioritized. These discussions included reflections on how the identified challenge impacts young people's access to and use of SRHR services within their communities. During this reflection session, participants also shared personal experiences, adding depth and context to the discussions.

To address the priority challenge, participants proposed actionable strategies and reflected on their feasibility, taking into account available resources and capacities. This iterative process ensured that the strategies were practical and achievable. The proceedings of each meeting were transcribed verbatim by note-takers immediately after each session. These transcripts were analyzed, and the findings are presented in this study.

Data analysis

Discussions held in the native (Igbo) Language were translated into English. To ensure quality, the transcripts were cross-checked against the written notes for completeness and accuracy. The written notes also provided additional context, including nuances and non-verbal cues, which were used to enhance the transcripts and to assign appropriate labels.

Thematic analysis was conducted using an inductive approach. Microsoft Excel was used to organize and analyse the data from the transcripts of the AL deployment meeting discussions. The analysis focused on two main themes, which were the outputs of the AL deployment meeting. These themes are: priority challenges in the provision of SRHR services to young people and actionable strategies to address the priority challenges. The sub-themes were generated inductively from the transcripts and this involved a thorough review of transcripts to identify patterns. Supporting quotes were extracted to validate the sub-themes.

Ethical considerations

Ethical approval for the study was obtained from the Health Research Ethics Committee of The University of Nigeria Teaching Hospital Enugu and the Research and Ethics Committee of Ebonyi State Ministry of Health. Participation was voluntary and participants were not coerced into participating in the study. The participants were required to sign or thumbprint a written informed consent before each session. However, before signing, participants were informed of the objectives of the study, its relevance and the methods that would be used. Privacy and confidentiality were assured, and data collected were anonymised as codes were used.

Results

Demographic characteristics of action learning participants

The demographic characteristics of the participants in the action learning groups are provided in Table 2. While the majority of healthcare providers are female, the community participants were evenly distributed across most of the AL groups.

Prioritized challenges in the provision of SRHR services to young people

The action-learning process led to the prioritization of a challenge faced by young people in accessing friendly SRHR services in their communities. Hence, one priority challenge was identified by each AL group making it a total of six identified priority challenges in the study area. The six priority challenges faced in the context of SRHR services were described in detail along with their connection to the principles of the gender transformative approach outlined by Rutgers [30]. These challenges and actionable strategies which were subsequently developed by the action learning groups to address prioritized challenges are presented in Figure 2. These challenges and actionable strategies are linked to their connecting GTA principles (see Figure 2)

Client-related challenges

The action-learning process led to the prioritization of two client-related challenges by two AL groups.

Table 2: Socio-demographic characteristics of AL participants in the six groups

Variables	Abakiliki	Ezza-south	Ikwo	Izzi	Ohaozara	Afikpo-south
Category						
Healthcare providers	12	10	10	06	06	10
Community members	12	10	10	06	06	10
Sex distribution for healthcare providers						
Male	00	00	00	00	01	00
Female	12	10	10	06	05	10
Sex distribution for community members						
Male	06	06	05	04	03	07
Female	06	04	05	02	03	03
Community members position						
Young people and youth leader	02	02	01	02	02	03
Women leader	03	03	03	02	01	02
Religious leader	01	00	02	00	01	02
Community leader	01	01	03	00	01	01
Ward development chairman	05	04	01	02	01	01
Age distribution of healthcare providers						
19-28 years	03	00	03	02	01	02
29-38 years	02	02	01	01	00	03
39-48 years	04	05	04	01	03	05
49-58 years	01	02	01	02	02	01
59 & above	02	01	01	00	00	00
Age distribution of community members						
19-28 years	02	02	01	01	02	03
29-38 years	04	02	03	02	02	02
39-48 years	04	06	05	01	00	03
49-58 years	01	00	00	02	02	02
59 & above	01	02	01	00	00	00

These challenges include that; young girls are hesitant to seek SRHR services, like contraceptives, due to fear of being noticed or judged or labelled as promiscuous; a lot of young girls are unaware of their rights to access SRHR services.

Community level challenges

We found that the priority challenges identified by three action learning groups were community-level challenges. These challenges include that; young men/boys do not support or encourage their sexual partners to use contraceptive services provided at the PHCs; there is a misconception about contraceptives among young girls who believe that implants, injectables, and oral contraceptives cause infertility; and the backlash from community members, including parents and spouses, affects how HCWs provide SRHR services to young people.

Provider-related challenge

Healthcare providers also face challenges. One of the action learning groups prioritized a provider-related challenge. This challenge is that some PHC workers feel uncomfortable providing certain SRHR services, especially contraceptives to unmarried young clients due to their beliefs and fear of repercussions from the community members.

Linking identified challenges to the principles of GTA

Sexual rights – denial of sexual rights

When primary healthcare workers deny young people access to SRHR services like contraceptives or speak rudely to unmarried young people seeking these services, they violate the sexual rights of these young individuals and discourage them from seeking SRHR care.

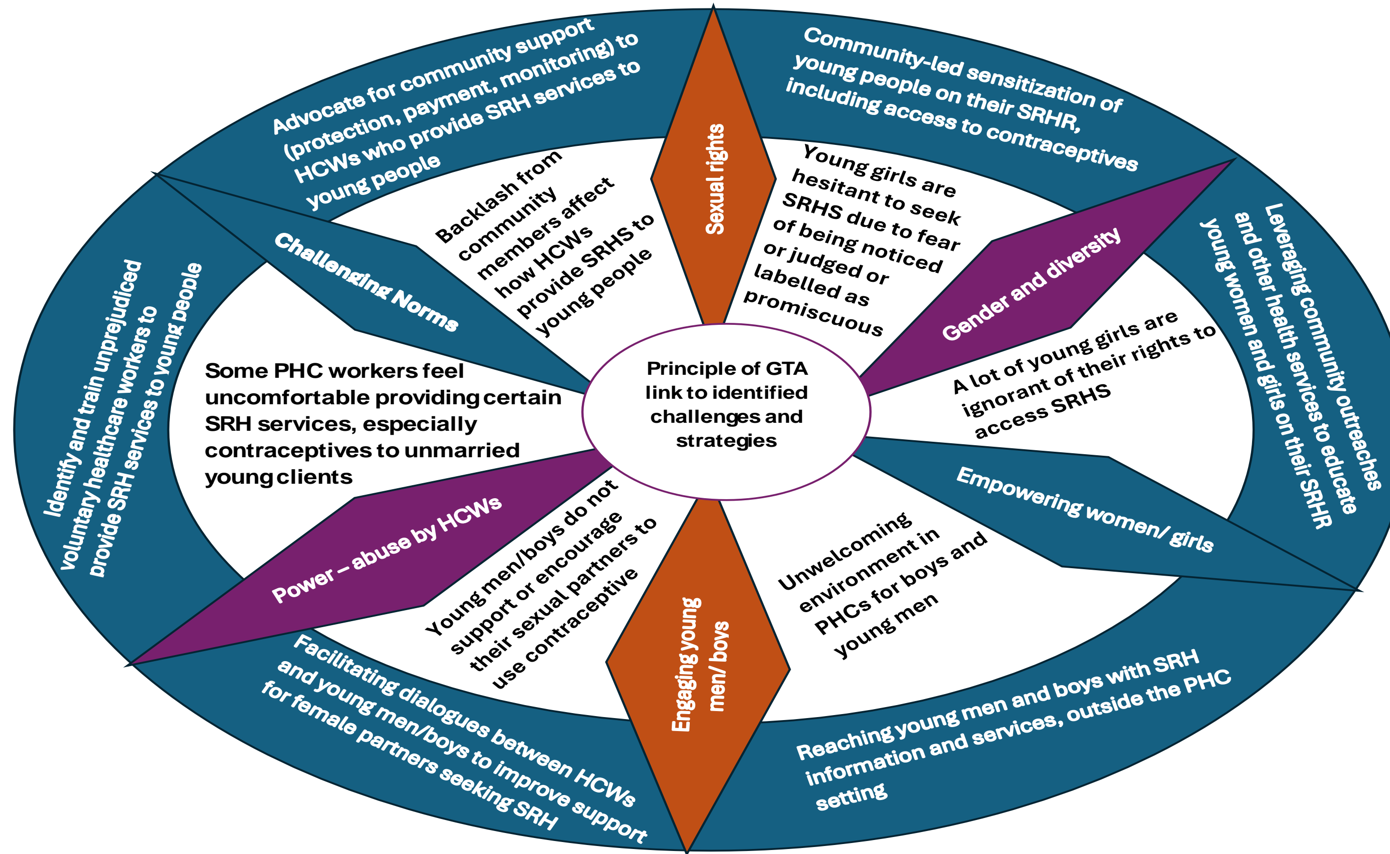

Figure 2: The prioritized challenges and proposed strategies to address the challenges linked to the principles of gender-transformative approach

'When a young girl 15 years enters the facility to access contraceptive services, some healthcare workers will speak rudely and harshly to her especially if she is not yet married and out of anger, the healthcare worker will talk to this young girl anyhow. This may even make the young girl not return to the facility to demand any health service' – female HCW Ohaozara.

Gender and diversity – discrimination of young girls

Refusal to provide some SRHR services particularly contraceptives to young unmarried girls, underscores the pervasive gender biases which are often rooted in societal norms. Gender discrimination in healthcare settings can have significant negative impacts on young girls, including feelings of shame, and reluctance to seek necessary health services in the future. It also perpetuates harmful gender norms that suggest young women should not have control over their sexual health, while young men are granted more freedom and access.

I want to be honest and tell you this thing that happened to me last month. I went to the health center to get a condom from the matron working there, but she refused to give it to me telling me there was no condom. So, I told my boyfriend about it and we went together, but I waited for him outside the gate. The same matron gave him one packet. Till now I still feel bad about it… - Young Girl Abakaliki

Challenging norms and behaviours

PHC workers are uncomfortable providing SRHR services to unmarried young clients, especially girls due to prevalent biases and stigma within communities, where parents often oppose the provision of SRHR services to young people. PHC workers also mentioned that young men usually disallow their female partners from using contraceptives.

'Parents feel that young people are too young to visit healthcare facilities and that healthcare workers providing sexual and reproductive health (SRHR) information or services to them are not doing the right thing. They feel that offering SRHR services to young people will expose them to unhealthy sexual behaviours. Even some healthcare workers are like that. They think that they are protecting them [young people]' - male youth leader Edda

'I had an experience with a young girl who came for contraceptive services. After counselling, she chose an implant. However, she returned to the facility three weeks later, demanding its removal. During our discussion, I discovered that her boyfriend had forced her to remove the contraceptive device, threatening to end their relationship if she didn't comply.' – female HCW Edda

Power – abuse of power by HCWs

Criticizing, scolding, or withholding services by healthcare workers is a demonstration of power over their young clients. This behaviour can prevent girls from accessing essential health services and reflect the power imbalances that a gender transformative approach aims to address.

Empowering young girls/women – information disempowerment

Young girls' lack of awareness regarding their rights to access SRHR services, and their misconceptions about contraceptives, including the belief that they may cause infertility, underscores the need for their empowerment.,

'Some of our young people do not even know that they have the right to walk into the health facility and access health services. So, they find it very difficult to walk into the health facility to even collect condoms.' – Female HCW Edda

'Yes, they are ignorant of contraceptive services. Young girls of this age range (13 to 19 years) feel that the contraceptive services are not made available for them to access but some of the older ones come to access it. Even the young boys are aware of these services, and they come for condoms but the young girls are not aware that they can come to the facility to access these services.' – Female HCW Abakiliki

Engaging young men and boys – unwelcoming PHC environment

Young men and boys often perceive PHCs as primarily serving the health needs of women and girls. Hence, they do not feel included in PHC services and would rather seek healthcare elsewhere. This limits their exposure to youth-friendly SRHR services and their understanding of

what it entails. This lack of understanding may negatively influence their support for female partners who desire SRHR services, particularly contraceptives, from PHCs.

'Why we talked about poor male engagement is because most of them feel that the facility is for pregnant women, delivery, and immunization of children. …. Some of them do not even support their spouse to access contraceptive services in the facility... – Female HCW Edda

Actionable strategies for addressing the priority challenges and their connection to the principles of GTA

A total of seven strategies that cut across the six principles of GTA were co-designed by AL teams. These strategies were categorized into four namely young client targeted strategies, community targeted strategies, provider targeted strategy, and a provider and client targeted strategies.

Young client-targeted strategies

The action learning groups developed three key young-client-targeted action strategies to improve SRHR services for young people. These strategies include; reaching young men and boys with SRHR information and services, outside the PHC setting; leveraging community outreaches and other health services to educate young women and girls on their SRHR; and community-led sensitization of young people on their SRHR, including access to contraceptives. These actionable strategies are described in detail.

Reaching young men and boys with SRHR information and services, outside the PHC setting

Based on the finding that young men and boys did not feel comfortable attending PHCs that have come to be known as a place for women and children, participants proposed an action strategy that will involve HCWs collaborating with community leaders to take SRHR information and services to young men and boys in the places that they are most comfortable. This strategy aligns with principles related to promoting male engagement.

'We (community leaders and healthcare workers) also agreed in our group to sensitize our young boys concerning the issue of not allowing young girls to access contraceptive services in the facility during youth meetings. We will include it as an agenda that will be carried out during our monthly youth meetings. We will sensitize them on the need for them to also utilize the SRHR services in the facility because the services are not only for women and children.' – male community leaders -Edda

Community-led sensitization of young people on their SRHR, including access to contraceptives

Another AL group developed a strategy that focuses on educating young people during youth meetings. The group emphasized that through health education on SRHR services, young people will be made aware of their SRHR rights and how to access services.

'Our young people need to be informed of their rights to access contraceptives that are made available in the facility. For those of them in the community, we can go to their various group meetings like village youth meetings.' –Female community leader Edda

Leveraging community outreaches and other health services to educate young women and girls on their SRHR

This strategy established by one of the AL groups aims to provide SRHR education that addresses the specific health concerns and myths that young girls may face regarding contraception. They highlighted that by informing young girls of their rights and providing accurate information, they will be empowered with the skills to make informed and autonomous decisions about their health, which is a core principle of a gender transformative approach.

'We need to sensitize them and this can be carried out in their schools. We can go to their schools during their moral instruction days, that is every Thursday to inform them of their SRHR rights. I know that Izzi-Nnuhu people have this group meeting that only those teenage mothers attend. We can also leverage on that to sensitize them' – female HCW Abakiliki

'Most of our mothers come to the facility either for antenatal, immunization or other maternal health services. So, sensitizing our mothers on the need to inform and support their young girls or even their

siblings to come for the SRHR services including contraceptives provided in the PHC is important. So, during our health talks, we will incorporate SRHR rights and available services for young people.' - female HCW Izzi

Community-targeted strategies

Our study shows that two actionable strategies target reaching the community members and leaders to support SRHR services for young people. The two strategies include; HCW-led sensitization of adults on the SRHR of young people during community gatherings; and advocating for community support (protection, payment, monitoring) to HCWs who provide SRHR services to young people.

HCW-led sensitization of adults on the SRHR of young people during community gatherings

A different AL group designed a strategy which focuses on challenging unequal gender and social norms by educating parents and adults (including men) about the SRHR of young people. This group argues that this strategy challenges existing norms that limit girls' access to SRHR information and services.

'The best we can do is to sensitize our people, especially parents with young children because of this ignorance on the need to allow our young girls and boys to access SRHR services and condoms that are provided in the facility.'- Male community member Edda

Advocate for community support (protection, payment, monitoring) to HCWs who provide SRHR services to young people

A strategy that primarily addresses the principle of power in GTA was developed. This strategy involves community involvement in SRHR service delivery by protecting HCWs from community backlash, providing financial incentives and monitoring to voluntary HCWs that provide SRHR services to young people. Community monitoring will ensure the accountability of the HCWs in SRHR service delivery.

"...but you know that things are hard; anything you are doing without money will not work. What I am saying is that even if it is small something, I mean money, like an incentive that you provide for the voluntary health worker that will go a long way in helping them in this work [provision of youth-friendly health services]. Nze is here, we will create time to talk to the Igwe about it. I know that if Igwe tells our children in the diaspora they will support us with this payment for volunteers..." - Male member Ohaozara'

Provider-targeted strategy

One of the action learning groups identified a strategy specifically targeting healthcare providers as their priority challenge is to address healthcare provider-related issues. This strategy involves identifying and training voluntary healthcare workers to provide SRHR services to young people.

Identify and train voluntary healthcare workers to provide SRHR services to young people

Through the action learning process, another group proposed that healthcare workers and community members would identify and employ willing voluntary healthcare workers who will be trained to support them in the provision of SRHR services to young people. Healthcare workers agreed that there is a need for re-orientation of healthcare workers who have been trained to provide gender-transformative youth-friendly SRHR services.

'I like what you people are doing and I am happy to be here listening to all this. As the WDC and also a member of Igwe's cabinet, I will bring up the issue of getting voluntary workers so that they will help those who are already working in the hospital to be providing the services, that reproductive services to our young ones. If the health workers train them and teach them what to be doing, I am sure they will be useful in providing the services' – male community member Ohaozara

Provider and client targeted strategy

One of the strategies designed during the action-learning process targeted both healthcare providers and young people. This strategy involves facilitating dialogues between HCWs and young men/boys to improve support for female partners seeking SRHR services.

Facilitating dialogues between HCWs and young men/boys to improve support for female partners seeking SRHR services

One of the action learning groups came up with this strategy which incorporates two principles of a gender-transformative approach such as promoting male engagement and challenging unequal gender and social norms. The group believes that the dialogues promote shared decision-making and are crucial for securing male support for SRHR services.

"…since it is like that, we have concluded that both the healthcare workers and community leaders will organize a community dialogue with the young boys and men in our different communities. ... Each community comprises several villages, so this dialogue will be crucial in ensuring that male partners and male family members encourage and support their sisters, female friends and sexual partners. Through this process, our young girls will feel supported." – community leaders -Edda.

Discussion

This study demonstrates that an AL process can be a valuable approach to understanding young people's SRHR challenges and developing strategies to promote gender-transformative youth-friendly SRHR services. To the best of our knowledge, this study is the first in Africa to apply an Action Learning (AL) approach to develop and implement gender-transformative strategies. This integration highlights the potential for creating tailored strategies that address the unique needs of young people, thereby enhancing their access to SRHR services, as supported by existing evidence on the efficacy of such gender-transformative approaches in improving SRHR outcomes[32–34].

The participation of diverse stakeholders, especially young people, in our AL approach, helped to provide a more nuanced and comprehensive understanding of the systemic issues. This created an environment where the voices of young people are heard and represented. By fostering this inclusivity, our study ensures that interventions are tailored to reflect the genuine SRHR service needs of young people in the community[35]. This is fundamental for creating policies that are responsive to the needs of all young people in the community. This supports the evidence that youth programs with youth involvement tend to do better as their involvement disrupts traditional power dynamics, enhancing intervention effectiveness and leading to more equitable and sustainable policy development[36,37]. The process helped identify client-related, healthcare provider-related and community-level barriers to youth-friendly SRHR services, from the perspective of multiple stakeholders. The identified challenges such as lack of male support for contraceptive use, young girls' lack of awareness and misconceptions about contraceptive services were similar to those described in the literature as myths surrounding the use of contraceptives[38]. Addressing these barriers requires a multi-faceted approach, including community engagement, and targeted interventions to educate and empower young people[38]. By understanding and tackling the root causes of these barriers, young people's access to and utilization of SRHR services can be improved, ultimately enhancing their SRHR outcomes.

Engaging young men and boys in SRHR dialogues and discussions inherently challenges traditional gender norms. By bringing young men into the conversation, the AL strategy challenges the deep-seated norms. The engagement is not merely about inclusion but about fostering an understanding among young men that their participation is vital for achieving holistic SRHR outcomes. Ruane-McAteer and colleagues revealed that there is a scarcity of interventions that actively involve men and boys in promoting gender equality, yet acknowledging that the ones in existence demonstrate potential effectiveness in enhancing SRHR behaviors[32]. However, in some regions, cultural resistance to GTA can hinder the effectiveness of such interventions. This emphasizes the need for more focused and sound research that not only engages men and boys but also adheres to a GTA backed by comprehensive evaluations[12,32].

By educating these community members and encouraging them to support and advocate for gender-transformative practices, the strategy helps in changing harmful norms. This shift can effectively drive significant changes in gender norms[39–41] which is essential for promoting gender equality. It enables a more supportive environment where young people can make informed and autonomous decisions about their SRHR.

Community engagement and dialogues have been used in similar contexts to address gender norms[42,43].

Our AL meetings provide a platform for participants to engage in critical reflection and facilitate action necessary to address and transform structural inequalities within communities. Evidence has shown that to improve the effectiveness of community interventions in behaviour change, creating an opportunity for reflection is important[44]. This reflective process aids in cultivating critical consciousness, a development effectively supported by the AL meetings[44]. Our AL approach aligns with the understanding that critical consciousness involves not just reflection but also empowerment to act and instigate change, as highlighted in various studies[45,46]. By identifying, employing, and training willing voluntary HCWs to support trained PHC workers in providing SRHR to young people, the strategy aligns with literature demonstrating that a capable and motivated workforce enhances service delivery and client satisfaction in various settings[47]. However, ensuring the sustainability of voluntary healthcare workers can be challenging particularly as some programs have struggled with maintaining volunteer motivation and retention without adequate financial and institutional support[48,49]. There is a need for the integration of voluntary HCWs into the health system workforce and the provision of incentives such as recognition awards, certificates, and financial incentives as these can be key to strengthening work motivation[48,49].

The action strategies prioritized during the AL meetings were appropriate as they included empowerment of young people, community awareness and engagement, challenging unequal gender and social norms and promoting equitable delivery of youth-friendly SRHR services. Strategies involving community awareness and engagement are crucial for building trust and collaboration among stakeholders, thereby ensuring sustainable change[50].

The AL approach shows the potential for understanding the challenges of young people with access to SRHR services and prioritizing GT strategies to address the challenges. Action strategies developed through this approach, in collaboration with the implementers, significantly bolster the likelihood of successful implementation and stakeholder buy-in, ensuring that unbiased SRHR services are provided to young people. This is further supported by studies highlighting the importance of sustained stakeholder engagement and iterative co-production of strategies, which bridge the gap between planning and effective action[50,51].

Study strengths and limitations

The strength of the study lies in its use of an innovative approach – action learning in prioritizing SRHR challenges and developing gender-transformative strategies. This provides guidance and lessons for policymakers and those implementing programs on how to apply AL in addressing SRHR challenges particularly, issues that are driven by norms and beliefs. However, considering the size and diversity of Nigeria, the study may have limited generalizability as the AL was implemented in one State in Ebonyi, Nigeria.

AL approach is not without challenges as the iterative process of meetings and action implementation can be a burden and a source of fatigue for the participants. The establishment of dedicated WhatsApp platforms for each group served as a digital support system, motivating healthcare workers to put into practice the agreed actions upon witnessing their peers doing the same within their communities. Another challenge faced in our action-learning intervention was the apprehension of healthcare workers about possible negative reactions from the community. However, by engaging in peer-to-peer learning and exchanging personal experiences, healthcare workers managed to overcome this barrier. Additionally, by collaborating with influential community members to implement actionable strategies, healthcare workers gained the confidence to address their fears.

Conclusion and policy implications

This study highlights the process of using the AL approach in understanding young people's SRHR challenges and developing strategies to promote gender-transformative youth-friendly SRHR services. By involving diverse stakeholders, particularly young people, the AL approach provided a comprehensive understanding of the systemic challenges in access and provisions of

youth-friendly SRHR services. The findings revealed significant challenges such as the lack of male support for contraceptive use, young girls' misconceptions about contraceptives, and biases among healthcare providers.

Policies that emphasise the importance of involving diverse stakeholders, especially young people, in the development and implementation of SRHR programs should be considered. This ensures that the programs are tailored to the actual needs and challenges faced by young people. Policies should promote gender-transformative practices by engaging both young men and women in SRHR dialogues as this helps to challenge traditional gender norms that hinder the effective use of contraceptives and other SRHR services. Supporting targeted education and awareness programs such as campaigns to address misconceptions and myths about contraceptive use is important. This will help to increase awareness among young girls and garner male support for contraceptive use. Also, there is a need for programs to prioritize the empowerment of young people, providing platforms for critical reflection and action to address structural inequalities. Implementing these policy recommendations can create a more supportive and inclusive environment for delivering youth-friendly SRHR services, which ultimately improves the health and well-being of young people.

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Conflict of interest

The authors declare that there are no conflicts of interest to declare

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Authors contributions

COM, OO, ICA and NE conceptualized the study. All authors were involved in designing and implementing the intervention. ICA, CA, CNE and ON produced the first draft of the manuscript. All the authors read, revised, and approved the final version of the manuscript.

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