



USAID
FROM THE AMERICAN PEOPLE

HRH2030
HUMAN RESOURCES FOR HEALTH IN 2030



Defining and Advancing a Gender-Competent Family Planning Service Provider: A Competency Framework and Technical Brief

SECOND EDITION

ACKNOWLEDGEMENTS

This competency framework and technical brief was developed by the HRH2030 consortium through the generous support of the United States Agency for International Development (USAID).

The development team consisted of Samantha Law (Chemonics International, lead author); Afeefa Abdur-Rahman, Michal Avni, and Lois Schaefer (USAID Bureau for Global Health) with support from Erin Owens, Kelly Cronen, Rachel Deussom, and Wanda Jaskiewicz (Chemonics International).

Kent Tangcalagan and Meskerem Damene were instrumental in field testing in the Philippines and Ethiopia, respectively.

We would like to thank the following individuals and organizations for their invaluable feedback including Anne Sprinkel (CARE); Anjala Kanesathasan (E2A); Kira Laffe (EngenderHealth), Patrick Ikani and Maryce Ramsey (FHI360); Sandra Jordan (FP2020); Rebecka Lundgren and Dominick Shattuck (Institute for Reproductive Health); Zuzana Kusynová (International Pharmaceutical Federation); Constance Newman (IntraHealth International); Mary Beth Hastings (Iris Group); Elizabeth Arlotti-Parish and Joya Banerjee (Jhpiego); Nancy Glass, Dr. Mojisola Odeku, Dr. Saratu Olabode-Ojo, Rael Odengo, Erin Portillo, and Claudia Vondrasek (Johns Hopkins University Center for Communication Programs); Nancy Harris (John Snow International); Jan Kumar; Lynn Bakamjian; Sarah Pappa (Palladium); Karen Hardee (Population Council); Shakira Franklyn (Seed Global Health); Upala Devi (United Nations Population Fund); Vineeta Gupta (University Research Company); Isabel Garcia, Patricia MacDonald, Reshmi Mehta (USAID Bureau for Global Health); Jill Gay (What Works Association); Susan Papp and Dani Murphy (Women Deliver).

Cover Photo Credit: Lan Andrian/GHSC-PSM

Contents

Acknowledgments	i
Acronyms	1
Introduction	2
Methodology	4
What is Gender Competency?	5
Theory of Change	5
Domains	5
Figure 1. Gender Competency for Family Planning Service Providers Theory of Change	7
Reproductive Empowerment	9
Improved Reproductive Health and Gender Equality	9
The Gender Competency Framework for Family Planning Service Providers	10
Knowledge, Skills, and Attitudes	12
Figure 2. Gender Competency Framework for Family Planning Service Providers	14
Application	16
Across the Health Workforce	16
Adaptation and Contextualization	17
Training	17
Figure 3. Advancing Gender Competency for Family Planning Service Providers Across the Health System	18
Demonstrating Gender Competency, Examples from Around the World	20
Annex A. Glossary and Resource Spotlight	22
Annex B. References	25

ACRONYMS

FP	family planning
GBV	gender-based violence
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
HRH	human resources for health
HRH2030	Human Resources for Health in 2030
IGWG	Interagency Gender Working Group
RH	reproductive health
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Health care providers have great potential to be powerful change agents and overcome biases to offer quality gender-sensitive and/or transformative services.

Introduction

Around the world, gender norms influence the ability of individuals, couples, and families to meet their desired family planning (FP) needs. Advances in FP have focused largely on increasing the availability of services and expanding access for women in the context of systemic barriers impeding FP access for all. However, decisions about whether, when, and how often to reproduce or to follow through with use of a chosen FP method are intrinsically tied to **gender** — how a society ascribes day-to-day roles, rights, and responsibilities to women and men. These pervasive gender and cultural norms may manifest in **power** imbalances that influence relationships between women and men, including health decision-making and the ability to equitably access services,

including reproductive health (RH) services (Commission on Social Determinants of Health, 2008). For example, in many contexts, a woman's ability to make her own RH decisions is often constrained by her partner's or father's control over economic resources and her ability to travel to seek care. Further, men's involvement in FP choices is often dictated by traditional gender norms associated with virility and masculinity, all of which affect women's and couples' ability to make voluntary and informed decisions about FP use.

Gender bias — the unequal treatment and/or expectations due to attitudes based on sex — on the part of health providers is a powerful inhibitor of access to and use of FP and RH information and services. Health care providers themselves often experience gender bias in the workplace, yet they can



A family planning provider in Zambia explains method options to a couple.
Photo Credit: Chemonics

also exacerbate or alleviate gender bias during client interactions. Provider bias and power impact the quality and accessibility of FP/RH care. For example, a health care provider may choose not to provide contraception to a married adolescent girl or restrict use of long-acting methods until a woman has had a child (High-Impact Practices in Family Planning, 2015). Female clients may not feel comfortable asking sensitive questions of their male provider and likewise male clients of a female provider.

Health care providers also have great potential to be powerful change agents and overcome biases to offer quality gender-sensitive and/or transformative services. For example, provider stigma had been a major barrier to successful human immunodeficiency virus (HIV) prevention, care, and treatment, but efforts to reduce stigma in health workers have shown positive results (Pulerwitz, et al., 2010).

The United Nations' general comment No. 22 on reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights) states that RH information should be provided in a manner consistent with the needs of the individual, taking gender into consideration (United Nations Economic and Social Council, 2016, p. 5).

Although gender issues manifest at all levels of health service delivery, FP services are a common intersection of health services and gender and create an opportunity for examining the impact of gender bias on the accessibility, availability, acceptability, and quality of services. Research shows that when **gender-transformative** approaches are included in FP/RH activities, they can:

- Change the negative effects of certain gender norms and stereotypes by empowering men and women to make informed choices (IntraHealth International, 2010)
- Improve FP service quality and availability (Rabie, et al., 2013)



A couple jointly discusses pregnancy in Zambia.
Photo Credit: Chemonics

- Advance positive behavior change in RH practices, such as health-seeking habits, addressing violence against women, and positive changes in attitudes related to RH (Barker, et al., 2010)
- Create opportunities for providers to clarify personal values and offer services in a nonjudgmental way (Stover, et al., 2016) to meet their clients' RH needs

Despite the recognized impact that gender norms, bias, and power can play in the ability of women, men, girls, and boys to make fully free and informed decisions about FP and RH, there has been insufficient guidance on how to ensure **FP providers** have adequate competencies to translate gender concepts into FP service delivery. FP providers may include health worker cadres such as nurses, nurse-midwives, community health workers/volunteers, health educators, clinicians,



Two community health workers in the Philippines discuss the HRH2030 Gender Competency Framework for Family Planning Providers.

Photo Credit: Alan Blue Motus, HRH2030

physicians, pharmacists, and private pharmacy workers. As countries make progress in key areas of health workforce development and expand the availability of and access to FP services, providers' self-awareness of gender and the skills needed to appropriately incorporate gender-equitable approaches are critical issues to address. Although descriptions of gender competency exist in general terms, no single definition is predominant, commonly used, or applied specifically to providers, particularly in the context of FP services.

Methodology

In collaboration with the United States Agency for International Development (USAID) Office of Population and Reproductive Health, the USAID-funded HRH2030 (Human Resources for Health in 2030) program sought to fill this gap by developing:

- Definitions of **gender competency** and of a **gender-competent FP provider** (see pp. 5 – 6); and
- A **Gender Competency Framework for Family Planning Service Providers** to

link gender and FP service provision with specific **knowledge, skills, and attitudes** to reduce provider bias and improve FP services (see Figure 2 on page 14).

Building on existing literature in gender and FP, HRH2030 first conducted a **desk review** as a foundation to develop the working definition of a gender-competent FP provider, domain areas, and specific competencies in the Gender Competency Framework for Family Planning Service Providers. The desk review took place between November 2016 and April 2017 and included published and grey literature on gender, FP service provision, and competency-based education and management. The desk review resulted in working definitions and a preliminary competency framework.

HRH2030 subsequently convened an **expert consultation group** of gender, FP, gender-based violence (GBV), and human resources for health (HRH) experts and practicing midwives and nurses for a consultative forum in Washington, D.C., in November 2017. These experts vetted the preliminary work and provided feedback for HRH2030 to incorporate into subsequent versions. To ensure a broad range of expertise after the initial expert consultation, HRH2030 next organized a virtual comment period in January 2018 to obtain feedback from global specialists on the updated work from multiple country contexts. To determine the applicability and relevance of the concepts and competencies, HRH2030 reviewed the framework with providers and stakeholder organizations in the Philippines in June 2019 and Ethiopia in March 2020. The technical brief, Theory of Change and Gender Competency Framework for Family Planning Service Providers are the results of this review process. All experts and organizations involved are included in the Acknowledgments section.

What is Gender Competency?

Competency is the capability to apply or use a set of related knowledge, skills, and attitudes required to successfully perform critical work functions and problem-solve according to established performance standards, including performing effectively on different occasions and in unexpected contexts. Competency-based education and training is an emerging approach to equip health workers with relevant knowledge and expertise to respond to identified health needs (Frenk, et al., 2010). Competency focuses on the performance of a specific outcome, emphasizing the results of education rather than its processes (Gruppen, 2012). Competencies may be used for preservice education or in-service training programs as a means to define what knowledge, skills and attitudes are requisite for service, as well as by regulatory bodies for accreditation and licensing to set standards and accountability mechanisms. When appropriately defined, competencies support the effective delivery of client-centered care and a means for measuring health workers' continuing professional development (Organisation for Economic Co-operation and Development, 2018). An example of using competencies for FP education and training is the Training Resource Package, which provides resources for standardized mandatory minimum core curriculum competencies for FP/RH service provision (Training Resource Package, 2012).

Based on the HRH2030-led process described above, experts in gender, FP, GBV, and HRH agreed on definitions for gender competency (see *right*) and a gender-competent FP service provider (see *p. 6*).¹ Gender competency is essential to

providers' ability to deliver equitable quality services to women, men, girls, and boys.

Defining gender competencies for FP service providers enhances the clinical competencies for FP/RH service provision. The six **domains** of gender competency for FP service provision seek to address gaps in provider knowledge, skills, and attitudes, including those that result in gender bias and undermine FP service equity and quality.

Theory of Change

Gender competency enables providers to more adequately and effectively meet clients' RH needs through quality services under a **rights-based approach to FP**, which affirms an individual's right to choose whether, when, and how many children to have, to act on those choices, and to access FP services free from discrimination, coercion, and violence (Family Planning 2020, 2018).

The theory of change for FP provider gender competency suggests that when FP providers are competent at addressing gender issues in FP through the six domains, they can contribute to **reproductive empowerment** (see *p. 7*) and, more broadly, improved RH and gender equality (see *Figure 1*). Each element of the theory of change is described below.

Domains

Domains are high-level groupings that organize competencies thematically (People that Deliver Technical Working Group, 2014). They are interrelated, overlapping, and bolster one another. Achieving gender competence is a dynamic process of mastering skills across these domains. Inherent to each

HRH2030 DEFINITION Gender Competency

Gender competency is the capacity to identify when and how different norms, social constructs, roles, expectations, power differentials, opportunities, and constraints assigned to women, men, girls, and boys are manifested in daily life, and how they might affect health and well-being, including how the provider's own attitudes and norms about gender and power affect professional interactions. Gender competency requires the application of appropriate knowledge, skills, and attitudes in daily work and interactions to communicate and treat people equitably and produce more equal agency and decision-making for women, men, girls, and boys, regardless of age or relationship status.

¹ Given the central importance of women's bodily integrity in reproduction, this work considers the expansion of women's agency as foundational. The competencies also emphasize the critical role men play as supportive partners and as users of contraception. Similarly, inclusivity is embedded in the goals and process of this work, although in the context of FP, the primary focus is women, men, girls, and boys of reproductive age.

HRH2030 DEFINITION Gender-Competent FP Provider

A gender-competent FP provider is a health worker with the capacity to identify how different norms, social constructs, roles, expectations, power differentials, opportunities, and constraints assigned to women, men, girls, and boys influence RH behavior and choices, and the awareness of how perception and treatment of male or female individuals influence the clients' voluntary and informed FP decision-making. A gender-competent FP provider strives to apply the needed knowledge, skills, and attitudes to create equitable opportunities for women, men, girls, and boys to make voluntary and informed FP/RH decisions based on their needs.

Gender competency of an FP provider consists of six domains:

1. Using gender-sensitive communication
2. Promoting individual agency
3. Supporting legal rights and status related to FP in accordance with rights and local laws
4. Engaging men and boys as partners and users
5. Facilitating positive couples' communication and cooperative decision-making
6. Addressing gender-based violence (GBV)

domain is the concept of power, which is manifested in both relationships between clients and client-provider interactions. Although many of the competencies are generalizable across different contexts, they should be tailored to specific local or country contexts, including those within fragile states and humanitarian situations. An FP service provider may demonstrate initial knowledge or skills within one or several of the domains but can constantly evolve by improving and reinforcing these skills, adjusting to changing contexts, and receiving more resources and training.

The six domains for gender competency for FP providers are shown in Figure 1 and further described below.

1. Using Gender-Sensitive Communication refers to the provider's ability to transmit information through verbal and non-verbal communication in a way that recognizes unequal power structures and promotes equality for all clients; it is client centered. It contributes to reproductive empowerment as providers share FP information with clients in an appropriate, comprehensible manner, resulting in clients' improved ability to act on choices that can achieve desired reproductive outcomes. Using **Gender-Sensitive Communication** is considered to be a prerequisite domain of gender competency because it facilitates a provider's ability to understand and support the FP needs of each individual. For example, a gender-competent provider must first identify their own power and influence as potentially more educated and informed than their clients, who may face intimidation and stigma discussing FP. This can involve reinforcing gender equitable behavior such as showing the same level of respect and attentiveness to both male and female members of a couple.

2. Promoting Individual Agency refers to the provider's capacity to support an

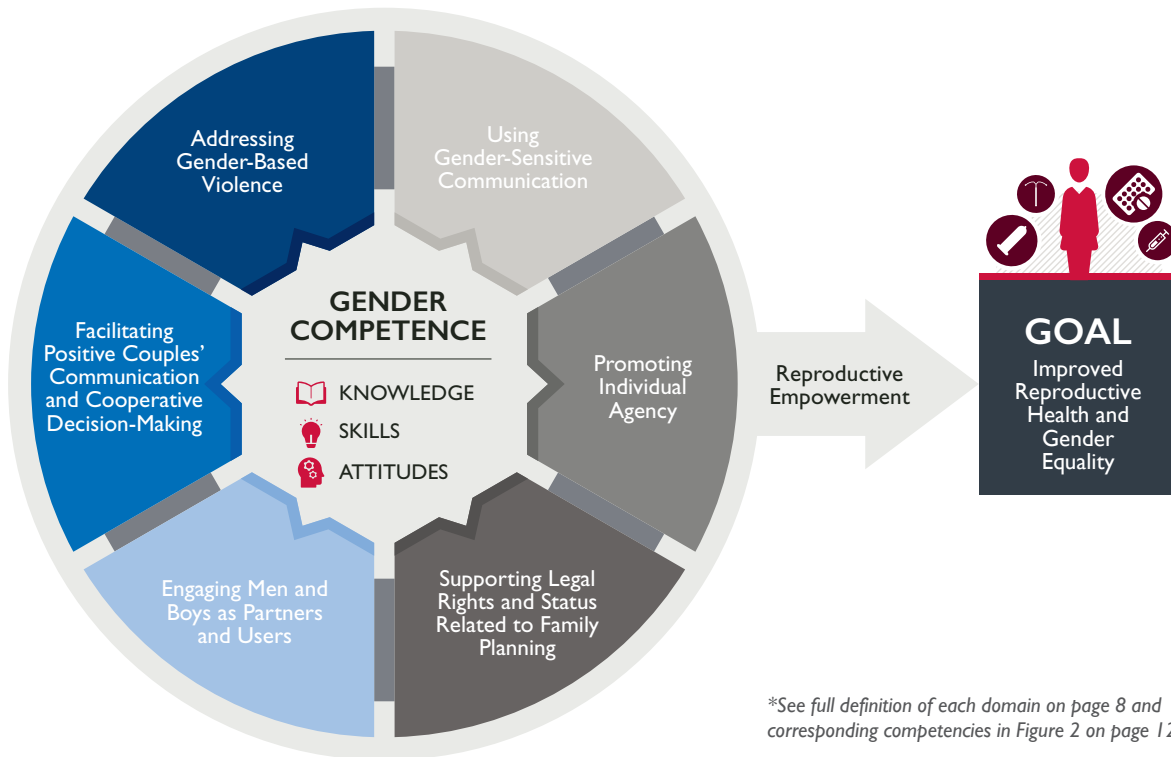
individual client's voluntary and informed decisions about whether, when, and how often to reproduce, without pressure to conform to gender and cultural norms.

This domain contributes to reproductive empowerment through providers being self-aware about their own gender biases and power to enable clients to make informed choices about using a FP method or not. For example, depending on a client's gender and relationship status, she or he may have varied reasons for selecting a specific FP method. Similarly, a couple may prefer a method that is the most effective for preventing pregnancy, or a woman may want to use a method that is not visible to her partner or peers. The provider who is gender competent recognizes the FP needs of the individual or couple as the priority over the provider's own personal beliefs. To achieve competencies under this domain, the provider must be able to facilitate an individual or couple to access FP information and make voluntary and informed decisions, which builds upon appropriate communication techniques and an understanding of gender and power defined under the first domain, *Using Gender-Sensitive Communication*.

3. Supporting Legal Rights and Status Related to FP refers to the provider's ability to provide information and services to clients in accordance with rights and local laws and without interference of personal bias. This domain contributes to reproductive empowerment through providers knowing local laws and policies and having the capacity to respond to the particular needs of a client to help them make voluntary and informed decisions about FP. This domain involves the ability to apply accurate knowledge in client-centered service provision, free from interpretation based on the provider's own perception of gender norms, roles, and expectations. To support the client's individual agency, the provider who is gender competent can also dispel any common misconceptions about rights related to FP. The second domain,

FIGURE I

GENDER COMPETENCY FOR FAMILY PLANNING SERVICE PROVIDERS THEORY OF CHANGE*



*See full definition of each domain on page 8 and corresponding competencies in Figure 2 on page 12.

Promoting Individual Agency, reinforces this domain, as FP providers must recognize a client's desired FP needs and agency prior to navigating laws and policies to enable a client to make voluntary, informed, and healthy decisions.

4. Engaging Men and Boys as Partners and Users refers to the provider's recognition of men and boys as supportive partners to women and as potential users of FP and can be demonstrated with men, women, and couples, but should always be anchored in women's preferences and consent. This domain contributes to reproductive empowerment through providers encouraging shared responsibility for FP between women and men, which ultimately promotes greater agency in RH decisions for all individuals (Klugman, et al., 2014). Meaningful engagement includes the provider's ability to involve male partners in the FP decision-making process while

protecting women's rights and agency, convey the potential value of FP to men and boys, and discuss RH intentions and concerns with both male clients and their female partners. Providers should also understand the roles men may perform in clients' voluntary and informed choice of FP methods. A gender-competent provider can also promote positive and healthy masculinities to contribute to shifting community norms and behavior change. Typically, providers have more interaction with female clients, but can demonstrate this competency even if they have limited facetime with men. For example, a gender-competent provider can discuss male FP use, quality of couple communication, and/or male support for contraception with a female client. Ideally they are also speaking with male clients. A provider can most effectively achieve this domain after mastering the previous domains.

Reproductive empowerment is the outcome of a transformative process whereby individuals expand their capacity to make informed decisions about their reproductive lives; increase their ability to meaningfully participate in public and private discussions related to reproduction; and act on their preferences and choices to achieve desired reproductive outcomes, free from violence, retribution, or fear.

Agency is the capacity for purposeful action that draws on social and material resources to realize preferences and choices, enhance voice, and increase power and influence.

(Adapted from Edmeades, et al., 2018)

The provider who is gender competent recognizes the family planning needs of the individual or couple as the priority over the provider's own personal beliefs.



A family planning user and a health promoter discuss contraceptive methods in Guatemala.
Photo Credit: Photoshare, © 2014 Haydee Lemus/PASMO PSI Guatemala

5. Facilitating Positive Couples' Communication and Cooperative Decision-Making refers to the provider's capacity to help clients articulate, discuss, and come to an agreement on reproductive intentions and to cooperatively make reproductive decisions as a couple. This domain contributes to reproductive empowerment through providers' ability to increase communication between partners and facilitate cooperative decision-making, which in turn leads to voluntary contraceptive use (Klugman, et al., 2014), greater satisfaction with FP methods, and less discontinuation (Hartmann, et al, 2012). Partners can include individuals who do not consider themselves coupled or whose reproductive decision-making involves multiple partners. It focuses on the provider's ability to positively impact cooperative client-client interaction, whether during couple counseling or when one client is present without his or her partner(s). Because partner involvement may not be appropriate in

every situation, the provider will need to ask a client about the role he or she wants his or her partner to play, a skill that builds on the second domain, *Promoting Individual Agency*. The provider who is gender competent in this domain can facilitate a conversation between partners about RH as well as promote a dialogue about method choice and concerns, such as side effects or fertility. Inherent to facilitating positive couples' communication and cooperative decision-making is an understanding of power and gender dynamics in the local context, such as the unequal power that can exist within intergenerational relationships and effective ways to engage both men and women.

6. Addressing Gender-Based Violence refers to the provider's ability to understand and recognize GBV, incorporate principles of do no harm into family planning services, provide appropriate referrals and reinforce the client's right to be treated with respect and live free of violence. This domain contributes to reproductive

empowerment through providers reinforcing the rights of all clients to be free from coercion, violence, or threats, including situations when a victim and his or her abuser may be clients. Providers not trained in GBV should know the available resources and understand how and when to provide a warm and compassionate referral and do no harm. Providers trained in GBV should follow national GBV protocols or other recognized approaches, such as the World Health Organization (WHO) LIVES approach (see *above right*), which is a first-line support and response approach to addressing GBV (WHO, 2014). Fundamental to addressing GBV is a provider who displays a nonjudgmental, supportive disposition and recognizes the norms that drive victim-blaming and stigmatization. Unless a provider is specifically trained in GBV response and a facility meets the WHO minimum conditions (Jhpiego, 2018), this domain does not recommend routine screening for GBV if clients do not have symptoms or do not disclose.

Reproductive Empowerment

Each domain of gender competency for FP providers describes how the provider contributes to reproductive empowerment. By improving a provider's gender knowledge, skills, and attitudes across the six domains, she or he will be more likely to:

- Identify how gender norms and biases for women, men, girls, and boys influence RH behavior
- Seek ways to address gender norms and biases
- Respond to the diverse needs of all clients and potential clients
- Deliver more equitable and high-quality FP services to a greater number of individuals, couples, and families
- Promote clients' free and informed choice

All of these outcomes contribute to a client's increased reproductive empowerment. However, mastery of these competencies by FP providers cannot achieve reproductive empowerment alone, as there are other individual, family, and systemic factors, that influence a client's reproductive empowerment. For example, a client's ability to go to the pharmacy to obtain his or her method of choice depends on their level of autonomy, mobility, safety, time, and financial resources. All of these factors effect a client's reproductive empowerment outside the provider's realm of influence.

The **WHO LIVES approach to GBV** emphasizes the following steps:

Listen closely, with empathy and no judgment

Inquire about needs and concerns

Validate experiences and show you believe and understand

Enhance safety

Support them to connect with additional services

Additional resources are linked at the end of this brief.



A married couple in India carefully reviews a pamphlet on family planning methods.
Photo Credit: Photoshare, © 2014 Lindsey Leslie

Provider-level interventions must be matched with systems-level interventions for greater gender equality and improved health outcomes.

Improved Reproductive Health and Gender Equality

Ultimately, increasing gender competency of FP providers can help transform inequitable gender norms and power differentials in client-client relationships and client-provider interaction, and in turn contribute to improved RH and gender equality. Achieving gender equality first requires empowerment at all levels to ensure decision-making and access to resources are weighted equitably for men and women (UNFPA, 2005). Providers who are gender competent contribute to reproductive empowerment and in turn gender equality, but this alone cannot achieve gender equality and improved RH. Provider-level interventions must be matched with systems-level interventions for greater gender equality and improved health outcomes.

To contribute to gender equality, gender-competent FP providers should work in environments that facilitate gender

competency. For example, if a provider is gender competent but the facility does not offer certain conditions, such as private rooms for screening, processes for GBV referrals, or confidential record keeping, the provider cannot fully deliver gender-equitable services. Resources such as the Tool to Assess the Gender Sensitivity of a Health Facility, developed by the USAID-supported Health Policy Plus project, help enable gender-competent providers to work in supportive systems (Irani, et al., 2015). Likewise, health services contribute only certain aspects to improved RH and gender equality.

The Gender Competency Framework for Family Planning Service Providers

The Gender Competency Framework for Family Planning Service Providers (*Figure 2, page 14*) lists the essential knowledge, skills, and attitudes, for a FP provider to be gender competent.



A young mother receives family planning counseling in Kenya.
Photo Credit: Photoshare, © 2014 John Kihoro/Tupange (Jhpiego Kenya)

APPLICATION EXAMPLE

A Gender-Competent FP Provider

A nurse manager who is gender competent provides FP services at a clinic in a rural village. Note how the nurse manager demonstrates gender competency across the six domains in her role over time.

This is an illustrative example to show the basic domains and concepts. For real-life examples that demonstrate various competencies based on our field testing in the Philippines and Ethiopia, see “Demonstrating Gender Competencies, Examples from the Field.” (pp. 17-18).

1. Using gender-sensitive communication, when an unmarried woman comes to the clinic seeking FP information and a contraceptive method that works for her, the nurse manager establishes a nonjudgmental rapport with the client by using respectful language and attentive body posture because she is aware the woman may feel stigma and discomfort accessing contraception as an unmarried woman in her community.

2. Promoting individual agency, the nurse manager asks the client about her FP needs, including efficacy, longevity, accessibility, and tolerance of side effects to ensure the client can make her own informed and voluntary choice. After time, if/when the woman marries, the nurse manager supports the woman with her changing FP needs, whether for spacing births or preventing pregnancy.

3. Supporting legal rights and status related to FP, the nurse manager knows there are no laws or policies in her country requiring the consent of a client’s husband or other family member when choosing to use FP. So, the nurse does not require consent beyond that of the client during their session because she acknowledges that each client has a right to make the final decision about using or not using FP.

4. Engaging men and boys as partners and users, the nurse manager respectfully asks the woman if she would like her husband or partner to join their session and respects her decision. The nurse manager uses affirmative language to encourage non-controlling, positive male participation in method choice and use, which the nurse manager recognizes may help with her client’s FP method satisfaction and continuation.

5. Facilitating positive couples’ communication and cooperative decision-making, the nurse manager gives equal attention to both the woman and her husband during couples counseling and discusses each partner’s concerns and preferences regarding FP methods.

6. Addressing gender-based violence, the nurse manager recognized that intimate partner violence is relatively common, and so she regularly assesses FP clients for the common signs and symptoms of GBV. The nurse manager has an established rapport with the trained GBV provider and knows how to make a warm and compassionate referral to clients when necessary. The nurse manager concludes FP counseling sessions with subtle but positive reminders about the right to be treated with respect and feel safe in a relationship.

Most competency frameworks are developed for specific health programs or services and are designed to reference a specific cadre of health workers. However, this gender competency definition and framework for FP providers can be tailored to apply across different health services, such as couples counseling or postpartum FP services. Additionally, FP services are provided by many types of providers, including nurses, midwives, community health workers/volunteers, health educators, clinicians, physicians, and pharmacists; the competency framework also applies to these different cadres.

Knowledge, Skills, and Attitudes

Knowledge, skills, and attitudes are essential building blocks of competencies and are also important elements of learning and development. All are required to successfully perform critical job functions and enable managers to

evaluate work, including establishing performance standards according to a specific role and setting. Training programs, such as preservice education for health professionals, should result in increased knowledge, strengthened skills, and improved attitudes about the subject matter. Learning objectives in any training program or curriculum should address knowledge, skills, and attitudes to holistically contribute to improved performance. Supervision and monitoring should be based on the desired knowledge, skills, and attitudes that are specified in service delivery standards, training programs, and performance expectations given in job descriptions.

In the framework, the essential knowledge, skill(s), and attitude(s) for each competency are defined and are identified using the icons shown in this key:



Delineating knowledge, skills, and attitudes is also critical for bridging the “know-do gap”. The know-do gap occurs when a provider has enough information or training on a concept or strategy to know how to do the function but may not be able to demonstrate the skill or perform the function effectively (Gruppen, 2012). Just as the domains bolster and build on one another, mastery in one set of competencies helps providers achieve mastery in other sets of competencies. In this competency framework, skills and attitudes involve translating a learned strategy or concept into action. However, some competencies are more specialized and may require extra training or support.

It is also worth noting that FP providers already have extensive responsibilities.



A couple attends a family planning counseling session with a family planning service provider in Nigeria. Photo Credit: Photoshare, © 2012 Akintunde Akinleye/NURHI



In India, a frontline health worker counsels a woman on family planning.
Photo Credit: Photoshare, © 2016 Girdhari Bora/SIFPSA mSehat

They may see many clients in a day, have other clinical and administrative responsibilities (e.g., HIV/AIDS services, pharmacy and supply chain responsibilities, facility organization and administration), may travel long or treacherous distances to conduct outreach or deliver mobile services, and often work in low-resource settings. Specific resources are required to complete all of these functions, such as a facility with adequate space for confidential counseling or a facility that meets the WHO minimum conditions for GBV screening.

This framework does not include a complete list of the competencies required for FP service provision. For example, the framework does not include clinical competencies, which cover how to use contraceptive methods safely and effectively once they are deemed to be medically appropriate. Rather, this framework projects a gender

lens on the competencies needed to improve client-provider interactions and bolster informed choice of FP methods for correct use and continuation.










These gender competencies should also not supplant good counseling or communication. However, they add another layer of efficacy to increase the proficiency of FP providers in delivering gender-equitable FP care, which should support an individual's right to choose whether, when, and how many children to have; to act on those choices; and to access services free from discrimination, coercion, and violence.


























This framework projects a gender lens on the competencies needed to improve client-provider interactions and bolster informed choice of FP methods for correct use and continuation.

FIGURE 2

GENDER COMPETENCY FRAMEWORK FOR FAMILY PLANNING SERVICE PROVIDERS

IMPORTANT: The competencies within this table focus on gender-related aspects of FP services and they do not address clinical competencies more generally. As such, they should be considered in conjunction with the most current comprehensive FP service guidelines and standards of care, such as the WHO Medical Eligibility Criteria for Contraceptive Use, fifth edition (WHO, 2015); Selected Practice Recommendations for Contraceptive Use, third edition (WHO, 2016); and Family Planning: A Global Handbook for Providers (WHO Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, Knowledge for Health Project, 2018).

Key	Knowledge 	Skills 	Attitudes 
Domain	Competency		
<p>1. Using Gender-Sensitive Communication refers to the provider's ability to transmit information through verbal and non-verbal communication in a way that recognizes unequal power structures and promotes equality for all clients; it is client centered.</p>	 a. Maintains relaxed, friendly, and attentive body postures and eye contact, as appropriate, to show respect for the client, regardless of gender.	 b. Identifies potential for unequal power among individuals that may exist because of gender, and impact access to information and services.	 c. Provides information to clients to obtain FP services, regardless of challenges created by the client's gender, including literacy, access to media and technology, and ability to attend counseling.
	 d. Recognizes own gender and influence as a provider and the potential to interfere with the provision of quality and equitable FP services.	 e. Integrates questions about family planning and reproductive health goals while clients are seeking other health services.	 f. Identifies opportunities to provide information on family planning during many life stage such as before first birth.
	 a. Asks about reproductive goals to open conversation and emphasize reproductive decisions are a choice.	 b. Reviews with clients the varied reasons for method choice, including efficacy, longevity, accessibility, and tolerance of side effects that may vary by sex, gender, age, safety, and relationship status.	 c. Discusses with clients the economic, social, and logistical factors that vary by gender and impact individual informed and voluntary choice and decisions to be sexually active.
	 d. Explains safe sexual practices in context of gender and power.	 e. Encourages all clients to make their own informed and voluntary reproductive choices regardless of gender, age, relationship status, or consent by family members (consistent with national FP/RH policy).	 f. Evaluates with client the process and feasibility of client obtaining and using his/her method of choice including accessibility and potential challenges based on sex and gender.
	 g. Acknowledges that the client has a right to make the final decision about using or not using FP and method choice.	 h. Accepts the client's chosen method, if available and medically indicated, and continues to provide services regardless of whether the selection matches the provider's own personal judgment of the client.	 a. Understands and supports the client's individual rights related to FP services and decisions to use contraceptive methods or not.
	 b. Helps the client understand his/her rights related to FP services and offers information on a full range of method options regardless of the client's gender, sexual orientation, relationship status, age, or occupation.	 c. Restates or translates the rights and policies related to FP service in comprehensible terms for all clients, when needed, to accommodate different literacy rates and according to gender.	 d. Provides equitable information, treatment, and services to all clients regardless of the type of relationship (ex: married, live-in partner, unmarried, non-monogamous).
<p>2. Promoting Individual Agency refers to the provider's capacity to support an individual client's voluntary and informed decisions about whether, when, and how often to reproduce, without pressure to conform to gender and cultural norms.</p>	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	 c. Restates or translates the rights and policies related to FP service in comprehensible terms for all clients, when needed, to accommodate different literacy rates and according to gender.	 d. Provides equitable information, treatment, and services to all clients regardless of the type of relationship (ex: married, live-in partner, unmarried, non-monogamous).
	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
<p>3. Supporting Legal Rights and Status Related to FP refers to the provider's ability to provide information and services to clients in accordance with rights and local laws and without interference of personal bias.</p>	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	 e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.
	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.	e. Maintains confidentiality and privacy regarding a client's choice or use of an FP method, including confidentiality and privacy with the client's partner or family, if desired.

Key	Knowledge 	Skills 	Attitudes 
Domain	Competency		
<p>4. Engaging Men and Boys as Partners and Users refers to the provider's recognition of men and boys as supportive partners to women and as potential users of FP. It can be demonstrated with male or female clients and couples, but should always be anchored in women's preferences and consent.</p>	 a. Recognizes how harmful displays of masculinity and femininity can result in unequal power between individuals and influence FP decision-making.	 b. Promotes positive male participation in method choice and use, including shared responsibility for FP and contraceptive use, while emphasizing the woman's right to voluntary and informed choice.	 c. Understands and can address myths and misconceptions about contraceptive use, including issues of power, control, and pleasure among men and women.
	 d. Recognizes men as potential users of FP by providing men with information on methods, counseling, and obtaining methods of choice, including speaking confidently about vasectomy to clients.	 e. Pursues opportunities to engage men and boys who may not traditionally seek FP services, without decreasing women's voice, choice, and ability to act on decisions.	 f. Brings up and provides to both male and female clients information on male-controlled and cooperative contraceptive methods and provides referrals when male contraception is not readily available.
	 g. Encourages men's sexual and reproductive health practices that respect women's rights and preferences with both male and female clients.	 a. Recognizes the potential for unequal power in decision-making between partners about FP choices before initiating couple communication and cooperative decision-making.	 b. Knows and can counsel on which contraceptive methods enable or require each partner's cooperation and decision-making.
	 c. Encourages the client to discuss his/her FP needs and preferences with the partner.	 d. Practices or role-plays scenarios to strengthen the client's ability to use his/her chosen FP method and discuss method choice and use with the partner, as needed.	 e. Asks the client if his/her partner or family would like to participate in current and future visits, emphasizing that it is the client's choice.
	 f. Facilitates discussion and shared decision-making between the partners, as desired by the client.	 g. Gives equal attention to both partners during couple counseling.	 a. Knows the definition of gender-based violence and intimate partner violence.
	 b. Can list the common signs and symptoms of GBV or GBV risk factors.	 c. Informs on which contraceptive methods can be used covertly with less chances of being detected.	 d. Understands how method choice may unintentionally lead to harm such as intimate partner violence and counsels with a do no harm approach.
	 e. Knows and understands the facility protocol for managing GBV, including referral for support services, reporting requirements, and whether the facility meets the minimum conditions for GBV screening.	 f. With all clients, reinforces a client's right to be treated with respect; free from threats, violence, or coercion by a partner, other family member, or a stranger; and free from victim-blaming and stigma.	 g. Offers clients compassionate and respectful counseling, including information about their right to choose the number and timing of children, and the right to live without sexual harassment or forced sexual relations.
<p>5. Facilitating Positive Couples' Communication and Cooperative Decision-Making refers to the provider's capacity to help clients articulate, discuss, and come to an agreement on reproductive intentions and to make joint reproductive decisions as a couple.</p>	 h. If client either discloses they have experienced violence or show signs and symptoms, asks about GBV.	 i. Using warm and compassionate counseling, refers the client to a provider trained in GBV response* and protects privacy and confidentiality (consistent with policy and law).	
			
			
			
			

**To reduce the risk of more harm, only providers trained in GBV counseling should counsel clients who report experiences with GBV. These providers should counsel using the GBV protocols or recognized standards that are consistent with policy and law.*

The Gender Competency Framework for Family Planning Service Providers articulates a model that can be adapted to consider the diverse contextual nuances of how gender is understood and experienced in FP provision and access.

Application

The Gender Competency Framework for Family Planning Service Providers articulates a model that can be adapted to consider the diverse contextual nuances of how gender is understood and experienced in FP provision and access.

Across the Health Workforce

From the highest level of the health system, ministries and HRH professionals can use the gender competency framework to enhance or add gender dimensions to cadre- or program-specific competencies. In addition, it can be used by health program managers and human resources professionals involved in the development of job descriptions, supervision strategies, preservice education curricula (WHO, 2007), in-service training plans and curricula, and licensing. At the facility level, managers and supervisors can use the framework

to complement gender-transformative supportive supervision (Leadership, Management, and Governance, USAID-funded project, 2017) and performance management of health workers, including private sector FP providers such as small drug shop owners and pharmacists, and community-based FP providers.

Gender competency is not mastered instantly or performed in vacuum. Gender competency should be incorporated and learned in pre-service education settings but takes practice and experience to master and sustain. Likewise, it is critical to have system-level support and resources to adequately demonstrate gender competency. At the same time, clients should know their rights in accessing respectful care.

To show the many ways gender competency can apply for the health workforce, Figure 3 (next page) visually



A nurse and doctor analyze the HRH2030 Gender Competency Framework for Family Planning Providers in the Philippines. Photo Credit: Kent Tangcalagan, USAID HRH2030/Philippines



A woman in Senegal holds a family planning display case containing a mix of contraception options.
Photo Credit: Photoshare, © PATH/Gabe Bienczyeki

illustrates the dynamics of the health labor market and the complex range of potential interventions to incorporate gender competency in strong HRH systems. The model uses the Health Labor Market Framework (Sousa, et al., 2013), which informed the World Health Organization's Global Strategy on Human Resources for Health, but adds a health worker-centered angle.

Adaptation and Contextualization

The Gender Competency Framework for Family Planning Service Providers is a global model for adaptation to the diverse contexts of FP service provision and gender:

Within the local health system.

FP providers represent a range of cadres that fulfill a broad array of tasks and responsibilities. Furthermore, these vary significantly in each country and local context.

For example, in one setting, the nurses might have the most interaction with clients to provide FP information and services because they have the most tasks related to family planning. In other contexts, doctors might have the most frequent interaction

with couples, since doctors are involved when couples elect for permanent methods. Still in other situations community health workers might have the most opportunities to engage with men within their outreach and mobile activities. Moreover, different health systems may have more or fewer resources such as referral services for GBV. Local laws must also be considered, such as definitions of marital rape.

Within the local culture. Critical to gender and gender competency is consideration of the sociocultural context in which women, girls, men, and boys live. Gender competency must always be informed by local culture and country context. For example, if female genital mutilation/cutting is practiced in a certain context, the framework should therefore be adjusted accordingly. Predominant cultural and religious practices and stigma can also influence gender and FP norms and may influence the provision of gender competent services. Terminology may need to be adapted for relevance to the local situation. For example, in some communities it may resonate to adapt "sexual orientation" to "choice of partner:"

Training

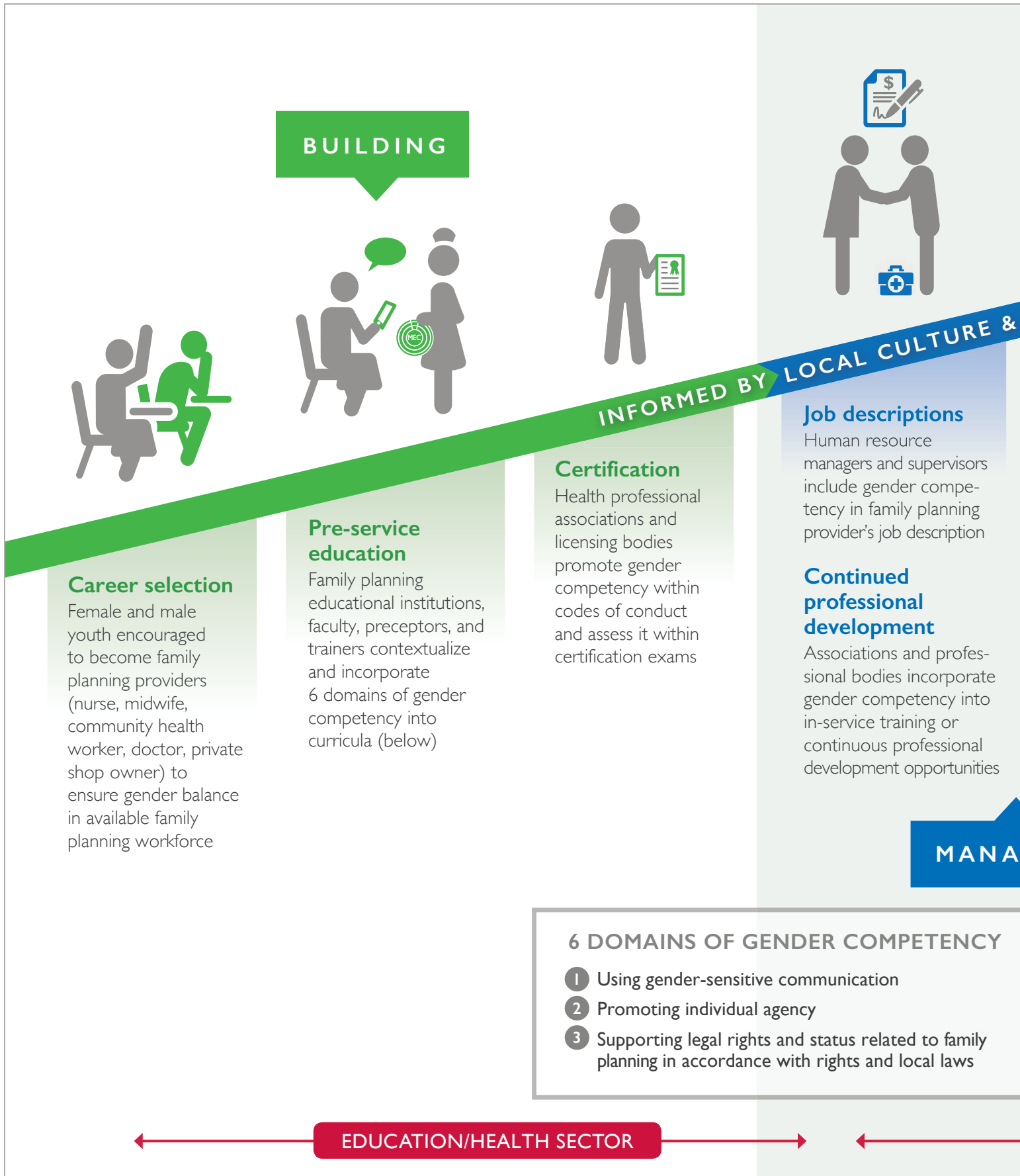
In an ideal setting, family planning providers enter the health workforce after pre-service training with the knowledge, skills, and attitudes to demonstrate gender competency. Across the health system, these competencies are reinforced through licensing exams, codes of conduct, job descriptions, in-service training, and supportive supervision. As a component of this, HRH2030 created a training that corresponds to the Gender Competency Framework for Family Planning Providers (see right).

HRH2030 TRAINING Gender Competency for Family Planning Providers

Coming soon!

FIGURE 3

ADVANCING GENDER COMPETENCY FOR FAMILY PLANNING SERVICE PROVIDERS ACROSS THE HEALTH SYSTEM





COUNTRY CONTEXT

Supervision

Supervisors and facility managers incorporate gender competency into performance management and supportive supervision strategies

Planning, financing, & policy making

Decision-makers ensure family planning providers are diverse, equitably distributed, equipped, and supported; gender competency included in accreditation

ENGAGING

- 4 Engaging men and boys as partners and users
- 5 Facilitating positive couples' communication and cooperative decision-making
- 6 Addressing gender-based violence

IMPROVED REPRODUCTIVE HEALTH & GENDER EQUITY

A gender competent health workforce provides more accessible, accountable, affordable and reliable family planning services to promote reproductive empowerment



Existing family planning providers apply and demonstrate appropriate knowledge, skills, and attitudes to deliver family planning services at the facility and community levels across the 6 domains to clients who know and can act on their rights

OPTIMIZING

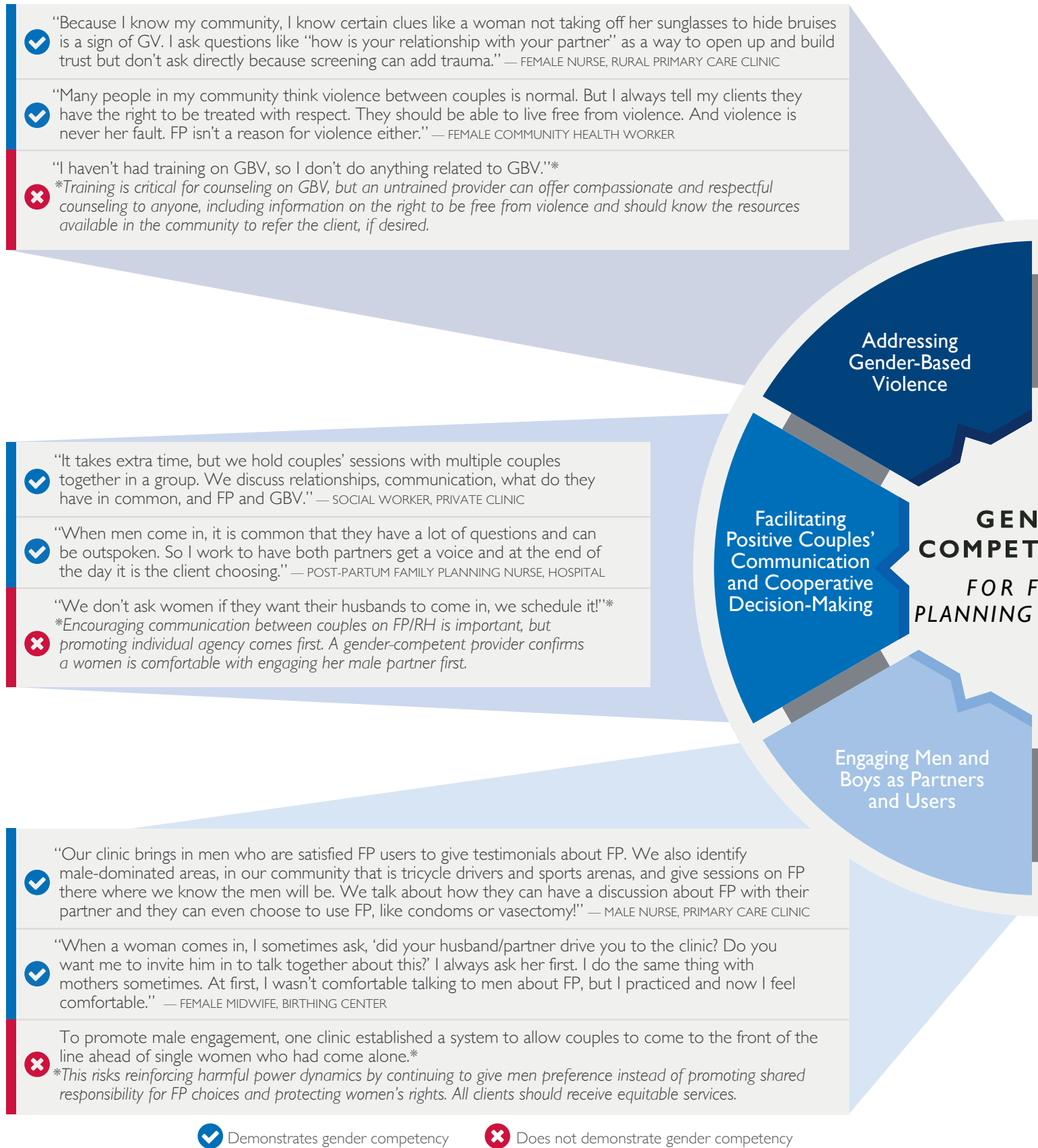
HEALTH LABOR MARKET

SOURCE: HIRH2030, 2019. Adapted from Sousa et al. 2013.

FIGURE 4

DEMONSTRATING GENDER COMPETENCY, EXAMPLES FROM AROUND THE WORLD

HRH2030 interviewed family planning providers in public and private facilities across Ethiopia and the Philippines on gender competency. The following examples were given. They have been altered for formatting and clarity and identities have been changed for confidentiality.



**DER
ENCIES
AMILY
ROVIDERS**

Using Gender-Sensitive Communication

Promoting Individual Agency

Supporting Legal Rights and Status Related to Family Planning

“Lots of unmarried women feel stigma coming in to talk about FP. I first assess the client’s level of FP knowledge to determine my communication style and I observe body language to notice their response and understanding. If they don’t understand, we say it differently. Then ask, ‘Do you understand?’ I have more training and information, so it is my responsibility to communicate the information in a way they understand and feel comfortable. I don’t want them to feel judged.” — FEMALE MIDWIFE, URBAN PRIMARY CARE CLINIC ✓

“For our hospital, we created a Facebook group for teenage girls where they can join to share their concerns including FP with a young female provider as administrator. Some feel more free that way.” — ADOLESCENT/YOUTH PROGRAM COORDINATOR AND NURSE, PRIVATE FACILITY ✓

“If you’re not married, why are you using family planning?” “Why are you having a child so young?” “Why are you here again?”*
**This is not gender competence because it is not treating the individual with respect and may abuse authority and make a client feel stigmatized or unwelcome. To build trust and rapport, a gender competent provider might make eye contact, welcome a client, and avoid unnecessary, judgmental questions. This can include receptionists, guards, and cleaners, all staff can be gender-competent!* ✗

“I ask “what are your reproductive goals?” to understand the person’s needs first. I also know they like a range of options for different reasons like not coming back often or privacy, so I keep track of what commodities are available and work with the pharmacy to ensure method mix.” — FEMALE MIDWIFE, HOSPITAL ✓

“I use the MEC wheel [WHO Medical Eligibility Criteria for Contraceptive Use, 5th edition] to help clients understand the methods that are medically indicated for them regardless of my own personal judgement and I also tell them, “I might have a different opinion, but you can choose.” — NURSE ✓

“What is the work of your husband? What does he think?”*
**A provider does not need to know about a partner to serve her client. A gender competent provider might ask, ‘do you want to discuss here how to talk to your partner about method choice?’ but would not assume a client is married.* ✗

“I keep the decisions of my clients between us. I tell them our time is confidential and I will not tell their husbands, partners, or parents about their choices.” — FEMALE PHARMACIST, PRIVATE FACILITY ✓

“When I am explaining everything, I say I will need the client’s consent but no one else’s. Some people think they need a husband’s consent. I tell them we encourage conversations about family planning between couples, but I only need the client’s consent in the end. It is always her choice.” — FEMALE DOCTOR, RURAL HOSPITAL ✓

“I can’t tell them about birth control pills or contraceptives until they have had their first baby.”*
**This is not gender competence because a provider should reinforce the client’s rights related to FP services and provide equitable information for voluntary and informed decisions regardless of type of relationship, family size, or any other factors.* ✗

Annex A. Glossary and Resource Spotlight

Agency: See “Reproductive Agency.”

Attitude: (noun) a state of mind, feelings, or beliefs about a matter. Derived from Bloom’s taxonomy of affective domain, which refers to the growth in feelings or emotional areas. Unlike knowledge and skills, attitude is not typically described or evaluated in terms of mastery levels; rather, a set of behavioral standards is described, and people are evaluated based on how consistently they demonstrate these standards. See also “Skills” and “Knowledge.”

Competencies: (noun) a set of measurable, observable, and clearly defined knowledge, skills, and attitudes that are critical to job performance and serve as a basis for assessing, developing, and evaluating people.

Competency: (noun) the capability to apply or use a set of related knowledge, skills, and attitudes (and sometimes behaviors) required to successfully perform critical work functions and problem-solve according to established performance standards, including performing effectively on different occasions and in unexpected contexts.

Competent: (adjective) having the necessary knowledge, skills, and attitude to do something successfully.

Do No Harm: (noun) the ability to avoid exposing people to additional risks through our action. It comes from taking a step back from an action to look at the broader context and mitigate potential negative effects on a person and/or a community (Charanle, 2018).

Family planning provider: (noun) anyone involved in the education, counseling, or provision of FP services. This can include nurses, nurse-midwives, community health workers/volunteers, health educators,

clinicians, physicians, pharmacists, and private pharmacy workers.

Gender: (noun) the economic, social, political, and cultural attributes, constraints, and opportunities associated with being male or female in a society . It includes the roles, behaviors, activities, rights, and responsibilities that a society considers appropriate for women, men, girls, and boys . Definitions of what it means to be a woman or a man vary within and between cultures and change over time . In this document, reference to gender is nuanced by societal differentiations, including age and relationship status, that influence gender roles in an RH setting . For example, a 30-year-old married woman may have a very different experience seeking health services compared with an 18-year-old unmarried woman .

Gender-based violence: (noun) is an umbrella term for any harmful threat or act directed at an individual or group based on actual or perceived biological sex, gender identity and/or expression, sexual orientation, and/or lack of adherence to varying socially constructed norms around masculinity and femininity. It is rooted in structural gender inequalities, patriarchy, and power imbalances. GBV is typically characterized by the use or threat of physical, psychological, sexual, economic, legal, political, social, and other forms of control and/or abuse. GBV impacts individuals across the life course and has direct and indirect costs to families, communities, economies, global public health, and development (U.S. Department of State and USAID, 2016). This definition may be nuanced in context by the existing national law and policy on GBV, as defined by the government, local nongovernmental organizations, or other advocacy groups and regulatory bodies.

Gender equality: (noun) the state or condition that affords women and

men equal enjoyment of human rights, socially valued goods, opportunities, and resources . Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people (IGWG, 2017).

Gender equity: (noun) the process of being fair to women and men, boys and girls. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men, boys and girls from operating on a level playing field (IGWG, 2017).

Gender-sensitive: (adjective) supporting actions, policies, interventions, or activities that proactively recognize the set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male, and the dynamics between and among women, men, girls, and boys.

Gender transformative: (adjective) supporting actions, policies, interventions, or activities that seek to alter harmful gender relations to promote equality. Gender transformative approaches attempt to promote gender equality by: 1) fostering critical examination of inequalities and gender roles, norms and dynamics, 2) recognizing and strengthening positive norms that support equality and an enabling environment, 3) promoting the relative position of women, girls and marginalized groups, and transforming the underlying social structures, policies and broadly held social norms that perpetuate gender inequalities.

Knowledge: (noun) an organized body of information, usually of a factual or procedural nature, which if applied makes adequate performance on the job possible. Derived from Bloom’s taxonomy

of cognitive domain, referring to mental skills . See also “Skills” and “Attitude .”

Masculinity: (noun) a set of attributes, behaviors, and roles associated with boys and men. In the FP context and traditionally, harmful notions of masculinity can refer to inequitable and unhealthy norms, including risk taking, lack of health-seeking behavior, and one-sided decision-making. These norms can influence RH and can be challenged via engaging men and boys in examining existing gender roles and norms that limit their ability to have healthier relationships and reproductive lives and support their partners' reproductive, sexual, and other health needs.

Partner: (noun) people who engage in sexual activity together; can be any gender, number, sex, and sexual orientation. Partners may be in a monogamous, exclusive relationship or not. A partner may mean a husband, wife, boyfriend, girlfriend, spouse, sex worker, stranger, or any other relation. In this definition, the important aspect is that the term “partner” is used to eliminate notions of heteronormative monogamous relationships exclusively.

Power: (noun) the capacity to make decisions freely and to exercise control over one's body in an individual's household, community, municipality, and state . Power also refers to the ability of individuals or groups to induce or influence the beliefs or actions of other persons or groups . An individual's power is dependent on several factors, including race, class, sexual orientation, gender, age, education, political assertion, etc . In this document, power represents access to decision-making and influence in relation to gender norms.

Power differential: (noun) the inherent disparity in power between individuals. In this case, it specifically refers to the greater power and influence that providers have

compared to their clients, based on employment, education, gender and/or sex. It also refers to the power imbalance in the client-client relationship, such as a male partner having greater decision-making power or a parent having greater influence than a female client.

Relationship status: (noun) association with a significant other; related to sexual interaction, commitment, emotional support, legal status, monetary affiliation, and communication. Examples include married, single, divorced, widowed, boyfriend/girlfriend, engaged, cohabitating, partner with multiple concurrent partners, transactional, monogamous, casual/one-night stand, forced relationship.

Reproductive agency: (noun) the capacity for purposeful action that draws on social and material resources to realize preferences, including voice, choice, and power related to reproduction.

Reproductive empowerment: (noun) the outcome of a transformative process whereby individuals expand their capacity to make informed decisions about their reproductive lives; increase their ability to meaningfully participate

in public and private discussions related to reproduction; and act on their preferences and choices to achieve desired reproductive outcomes, free from violence, retribution, or fear (International Center for Research on Women and MEASURE Evaluation, forthcoming) .

Rights-based family planning: (noun) an approach to designing and implementing activities with the purpose of fulfilling the individual's right to choose whether, when, and how many children to have; to act on those choices; and to access services free from discrimination, coercion, and violence.

Sex: (noun) the biological and physiological characteristics that identify a person as female or male. Differences in sex are concerned with males' and females' anatomy and physiology, including chromosomes, genitalia, and reproductive organs.

Skills: (noun) the proficient manual, verbal, or mental manipulation of data or things that is desirable, quantifiable, and measurable (e.g., typing skills, distinguishing colors). Derived from Bloom's taxonomy of psychomotor thinking, referring to manual or physical skills. See also “Knowledge” and “Attitude.”



A family planning provider explains the use of an intrauterine device (IUD) to a client in Egypt. Photo Credit: Photoshare, © 2003 Center for Communication Programs

HRH2030 RESOURCE SPOTLIGHT

FAMILY PLANNING

Training Resource Package for Family Planning

<https://www.fptraining.org/>

WHO Medical Eligibility Criteria for Contraceptive Use, Fifth edition

https://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/

Selected Practice Recommendations for Contraceptive Use, Third edition

https://www.who.int/reproductivehealth/publications/family_planning/SPR-3/en/

Family Planning: A Global Handbook for Providers

<https://www.who.int/reproductivehealth/publications/fp-global-handbook/en/>

GENDER-BASED VIOLENCE

WHO Recommendations and Resources:

https://www.who.int/violence_injury_prevention/violence/sexual/en/

Gender-Based Violence Quality Assurance Tool:

<http://resources.jhpiego.org/resources/GBV-QA-tool>

Training healthcare providers to help women survivors of violence (including WHO LIVES Approach)

<https://www.who.int/reproductivehealth/training-health-care-providers-help-women-survivors-of-violence/en/>

HUMAN RESOURCES FOR HEALTH

Human Resources for Health (HRH): Principles and Practices

<https://globalhealthlearning.org/course/human-resources-health-hrh-principles-and-practices>

MALE ENGAGEMENT

Essential Considerations for Engaging Men and Boys for Improved Family Planning Outcomes:

<https://www.usaid.gov/sites/default/files/documents/1864/Engaging-men-boys-family-planning-508.pdf>

Engaging Men and Boys in Family Planning: A Strategic Planning Guide:

<http://www.fphighimpactpractices.org/guides/engaging-menand-boys-in-family-planning/>

REPRODUCTIVE EMPOWERMENT

Framework for Reproductive Empowerment (Brief)

<https://www.icrw.org/publications/framework-for-reproductive-empowerment-brief/>

RIGHTS-BASED FAMILY PLANNING

Overview of Rights-based Family Planning

<http://www.familyplanning2020.org/rightsinfp>

Annex B. References

- Barker, G., Ricardo, C., Nascimento, M., Olukoya, A., and Santos, C. (2010). "Questioning Gender Norms with Men to Improve Health Outcomes: Evidence of Impact." *Global Public Health*, 5(5), pp. 539-53. Retrieved from www.ncbi.nlm.nih.gov/pubmed/19513910/ doi: 10.1080/17441690902942464. (Accessed February 1, 2018).
- Characle, J., Lucchi, E. (2018) "Incorporating the principle of 'Do No Harm': How to take action without causing harm." Retrieved from https://www.alnap.org/system/files/content/resource/files/main/donoharm_pe07_synthesis.pdf (Accessed May 27, 2020)
- Commission on Social Determinants of Health (CSDH). (2008). *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health.* Retrieved from http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf. (Accessed February 19, 2018).
- Croce-Galis, M., Salazar, E., and Lundgren, R. (2014). "Male Engagement in Family Planning: Reducing Unmet Need for Family Planning by Addressing Gender Norms." Retrieved from <http://irh.org/resource-library/male-engagement-family-planning-reducing-unmet-need-family-planning-addressing-gender-norms/>. (Accessed February 22, 2018).
- Eadmeads, J., Hinson, L., Sebany, M. and Murithi, L. (2018). "A Conceptual Framework for Reproductive Empowerment: Empowering Individuals and Couples to Improve their Health (Brief)." Washington, DC: International Center for Research on Women.
- Family Planning 2020 (FP2020). (2018). "Rights-Based Family Planning: Designing Programs to Respect, Protect, and Fulfill the Rights of Women and Girls." Retrieved from <http://www.familyplanning2020.org/microsite/rightsinfp>. (Accessed January 2, 2018).
- Frenk, J., Chen, L., Bhutta, Z.A., Cohen, J., Crisp, N., Evans, T., Fineberg, H., et al. (2010). "Health professionals for a new century: transforming education to strengthen health systems in an interdependent world." *The Lancet*, 376(9756), pp. 1923-1958. Retrieved from <http://nrs.harvard.edu/urn-3:HUL.InstRepos:4626403>. (Accessed July 31, 2018).
- Gruppen, L., Mangrulkar, R.S., and Kolars, J.C. (2012). "Competency-based education in the health professions: Implications for improving global health." *Human resources for health*. 10. 43. 10.1186/1478-4491-10-43. Retrieved from: <https://deepblue.lib.umich.edu/handle/2027.42/85362>. (Accessed August 2, 2018).
- Hartmann, M., Gilles, K., Shattuck, D., Kerner, B., and Guest, G. (2012). "Changes in Couples' Communication as a Result of a Male-Involvement Family Planning Intervention." *Journal of Health Communication*, 17(7), pp. 802-19. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/22545820/>. (Accessed February 1, 2018).
- High-Impact Practices in Family Planning. (2015). "Adolescent-Friendly Contraceptive Services: Mainstreaming Adolescent-Friendly Elements into Existing Contraceptive Services." Retrieved from <https://www.fphighimpactpractices.org/afcs>. (Accessed March 30, 2018).
- Interagency Gender Working Group (IGWG). (2002). "Gender Integration Continuum." Retrieved from <https://www.igwg.org/wp-content/uploads/2017/05/GendrContinuumCategories.pdf>. (Accessed January 2, 2018).
- IGWG. (2017). "Handout: Gender-related Terms and Definitions." Retrieved from <https://www.igwg.org/wp-content/uploads/2017/05/HandoutGenderTerms.pdf>. (Accessed July 18, 2018).
- International Center for Research on Women & MEASURE Evaluation (Forthcoming). "Empowerment: Moving Towards a Common Conceptual Framing and Measurement" [White paper]. Retrieved from https://healthcommcapacity.org/wp-content/uploads/2017/09/ICRW_WomensEmpowermentModel_Elements.pdf. (Accessed February 19, 2018).
- IntraHealth/PRIME II, USAID-funded Project. (2003). "Better Practices in Gender Sensitivity: Gender Sensitivity Assessment Tool." Retrieved from <https://www.k4health.org/sites/default/files/gender%20sensitivity%20assessment%20tool.pdf>. (Accessed January 2, 2018).
- IntraHealth International. (2010). "Preservice Education Family Planning Reference Guide, Unit 2: Gender-Sensitive Family Planning Services." Retrieved from https://www.intrahealth.org/sites/ihweb/files/attachment-files/MPsFPRG_unit2.pdf. (Accessed January 2, 2018).
- Irani, L., Hardee, K., and Bishop, M. (2015). "A Tool to Assess the Gender Sensitivity of a Health Facility: Pilot Tested in Afghanistan." Retrieved from http://pdf.usaid.gov/pdf_docs/PA00KM2R.pdf. (Accessed January 2, 2018).
- Jhpiego. (2018). "Gender-Based Violence Quality Assurance Tool." Retrieved from <http://resources.jhpiego.org/system/files/resources/GBV-Quality-Assurance-Tool--EN.pdf>. (Accessed February 9, 2018).
- Klugman, J., Hanmer, L., Twigg, S., McLeary-Sills, J., Hasan, T., and Bonilla, J.A.S. (2014). *Voice and Agency: Empowering Women and Girls for Shared Prosperity.* Retrieved from <http://documents.worldbank.org/curated/en/455941468152971238/pdf/881790WP0Voice00Box385212B00PUBLIC0.pdf>. (Accessed March 26, 2018).
- Leadership, Management, and Governance USAID-funded Project. (2017). "Gender Transformative Supportive Supervision Conceptual Framework." Retrieved from <http://www.imgforhealth.org/content/gender-transformative-supportive-supervision-conceptual-framework>. (Accessed March 14, 2018).
- Organisation for Economic Co-operation and Development (2018). "Feasibility Study on Health Workforce Skills Assessment: Supporting Health Workers Achieve Person-Centred Care." Retrieved from <http://www.oecd.org/els/health-systems/Feasibility-Study-On-Health-Workforce-Skills-Assessment-Feb2018.pdf>. (Accessed March 14, 2018).
- People that Deliver Technical (PtD) Working Group. (2014). *PtD Competency Compendium for Health Supply Chain Management: A Reference for Health Supply Chains, First Edition.* Retrieved from <http://iaph.org/wp-content/uploads/2016/05/PtD-Public-Health-SCM-Competency-Compendium.pdf>. (Accessed January 2, 2018).
- Pulerwitz, J., Michaelis, A., Weiss, E., Brown, L., and Mahendra, V. (2010). "Reducing HIV-Related Stigma: Lessons Learned from Horizons Research and Programs." *Public Health Reports.* Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2821857/>. (Accessed July 25, 2018).
- Rabie, T., Boehmova, Z., Hawkins, L., Tawab, N.A., Saher, S., and El Shitany, A. (2013). "Transforming Family Planning Outlook and Practice in Egypt: A Rights-Based Approach." Retrieved from <http://documents.worldbank.org/curated/en/351971468026087900/pdf/905960WP0Box3800July0160FINAL0PROOF.pdf>. (Accessed February 20, 2018).
- Sousa A, Scheffler R, Nyoni J, Boerma T. (2013). "A Comprehensive Health Labour Market Framework for Universal Health Coverage." *Bull World Health Organ.* 91:892-894. doi: 10.2471/BLT.13.118927 (Accessed November 1, 2019).
- Stover, J., Hardee, K., Ganatra, B., Moreno, C.G., and Horton, S. (2016). "Interventions to Improve Reproductive Health." *Reproductive, Maternal, Newborn, and Child Health: Disease Control Priorities, (Third Edition, Volume 2).* Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK361913>. (Accessed February 1, 2018).
- Training Resource Package. (2012). "Facilitator's Guide to the Training Resource Package for Family Planning—Appendix E: Illustrative Competency-based Skills Checklist." Retrieved from <https://www.fptraining.org/resources/competency-based-skills-assessment-checklist-family-planning-counseling>. (Accessed January 2, 2018).
- United Nations Economic and Social Council. (2016). "General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)." Retrieved from <https://www.escri-net.org/resources/general-comment-no-22-2016-right-sexual-and-reproductive-health>. (Accessed March 26, 2018).
- United Nations Population Fund (UNFPA). (2005) "Frequently Asked Questions About Gender Equality." Retrieved from <https://www.unfpa.org/resources/frequently-asked-questions-about-gender-equality>. (Accessed February 9, 2018).
- United States Department of State and the U.S. Agency for International Development. (2016). *United States Strategy to Prevent and Respond to Gender-Based Violence Globally, 2016 Update.* Retrieved from <https://www.state.gov/documents/organization/258703.pdf>. (Accessed March 29, 2018).
- World Health Organization (WHO). (2015). *Medical Eligibility Criteria for Contraceptive Use, Fifth edition.* Geneva: WHO. Retrieved from http://www.who.int/reproductivehealth/publications/family_planning/ExSumm-MEC-5/en/. (Accessed February 19, 2018).
- WHO. (2016). *Selected Practice Recommendations for Contraceptive Use, Third edition.* Geneva: WHO. Retrieved from: http://www.who.int/reproductivehealth/publications/family_planning/SPR-3/en/. (Accessed March 29, 2018).
- WHO. (2007). "Integrating Gender into the Curricula for Health Professionals, Meeting Report." Retrieved from http://www.who.int/gender/documents/GWH_curricula_web2.pdf. (Accessed January 2, 2018).
- WHO. (2014). *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.* Retrieved from http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf. (Accessed January 2, 2018).
- WHO, Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, Knowledge for Health Project. (2018). *Family Planning: A Global Handbook for Providers (2018 update).* Retrieved from <http://apps.who.int/iris/bitstream/10665/260156/1/9780999203705-eng.pdf?ua=1>. (Accessed February 21, 2018).



A health staff member provides counseling services on family planning to a couple in Vietnam.
Photo Credit: Photoshare, © 2009 Nguyen Quoc Phong

Program Partners

- Chemonics International
- American International Health Alliance (AIHA)
- Amref Health Africa
- Open Development
- Palladium
- ThinkWell
- University Research Company (URC)

About HRH2030

HRH2030 strives to build the accessible, available, acceptable, and high-quality health workforce needed to improve health outcomes.

Global Program Objectives

- 1. Improve performance and productivity of the health workforce.** Improve service delivery models, strengthen in-service training capacity and continuing professional development programs, and increase the capacity of managers to manage HRH resources more efficiently.
- 2. Increase the number, skill mix, and competency of the health workforce.** Ensure that educational institutions meet students' needs and use curriculum relevant to students' future patients. This objective also addresses management capability of pre-service institutions.
- 3. Strengthen HRH/HSS leadership and governance capacity.** Promote transparency in HRH decisions, strengthen the regulatory environment, improve management capacity, reduce gender disparities, and improve multi-sectoral collaboration for advancing the HRH agenda.
- 4. Increase sustainability of investment in HRH.** Increase the utilization of HRH data for accurate decision-making with the aim of increasing investment in educating, training, and managing a fit-for-purpose and fit-for-practice health workforce.



www.hrh2030program.org

This material is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-15-00046 (2015-2020). The contents are the responsibility of Chemonics International and do not necessarily reflect the views of USAID or the United States Government.

© Chemonics 2020. All rights reserved.