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

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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) (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 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 the right to sexual and 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)
— Advance positive behavior change in RH practices, such as health-seeking habits, questioning 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, 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. 3 – 4); 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 12).

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. The technical brief, concepts, and Gender Competency Framework for Family Planning Service Providers are the result of this peer review process. All experts and organizations involved are included in the Acknowledgments section.

To describe the rationale and evidence used in this process to define a gender-competent FP provider and develop the Gender Competency Framework for Family Planning Service Providers, a Theory of Change section is included on page 4.

**What is Gender Competency?**

**Competency** is 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. 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 and skills 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 pp. 4). Gender competency is essential to providers’ ability to deliver equitable quality services to women, men, girls, and boys, regardless of age or relationship status.

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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.
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 next page) 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 domain is the concept of power, which is manifested in both client-client relationships 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 communicate effectively to mitigate or overcome the gender-based cultural, educational, economic, or other power differentials that impact access to FP information and services. This can involve reinforcing gender equitable behavior such as showing the same level of respect and listing 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 having self-awareness 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, 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. 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. They should also understand the roles men may perform in clients’ voluntary and informed choice of FP methods. Providers may also need to adjust to clarify basics of reproduction and FP before moving forward with shared decision-making around FP and RH. A gender-competent provider can also promote positive and healthy masculinities to contribute to shifting community norms and behavior change. A provider can most effectively achieve this domain after mastering the previous domains.

5. Facilitating Positive Couples’ Communication and Cooperative Decision-Making refers to the provider’s capacity to help clients articulate, discuss, and negotiate reproductive intentions and to make joint 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). 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. Partners can include those who do not consider themselves coupled or whose reproductive decision-making involves multiple partners. 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 power differentials 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 respond to GBV through brief empathetic counseling, safety planning, and appropriate referrals. 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. A gender-competent provider should understand how and when to provide a warm and compassionate referral for a client to a provider trained in GBV. If trained, the provider should use the World Health Organization (WHO) LIVES approach (see above right), which is a first-line support and response approach to GBV (WHO, 2014). Fundamental to addressing GBV is that the provider displays a nonjudgmental, supportive disposition, recognizing 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. Achieving competency in this domain depends on understanding and applying each of the preceding domains. FP providers frequently require additional training, specialization, and resources to achieve it.

Reproductive Empowerment
Each domain of gender competency for FP providers describes an aspect of the provider contributing 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

The WHO LIVES approach 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

A married couple in India carefully reviews a pamphlet on family planning methods.

Photo Credit: Photoshare, © 2014 Lindsey Leslie
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 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.

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 no longer weighted in favor of men or women, so that both women and men can fully participate as equal partners in productive and reproductive life (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.

Gender Equity and Equality

**Gender equity** is 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.

**Gender equality** is 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.

In this work providers who are gender competent contribute to an equitable process when they assess the needs of an individual based on the gender issues in the client’s particular context to provide quality treatment, which may look different for different individuals. The actions of a provider who is gender competent seek to contribute to the goal of gender equality. The provider may exhibit gender competency but cannot achieve equality alone if other factors are not met, such as shared responsibility at home.
1. **Using gender-sensitive communication**, when an unmarried woman comes to the clinic for 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, providing her complete information on method options, and confirming the client’s comprehension of choices and services.

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, 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 family or husband to her use of FP. So, the nurse does not require consent beyond the client’s 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 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 with FP methods.

6. **Addressing gender-based violence**, the nurse manager recognized that domestic abuse 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.

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.
The Gender Competency Framework for Family Planning Service Providers

The Gender Competency Framework for Family Planning Service Providers (Figure 2, page 12) lists the essential knowledge, skills, and attitudes, for a FP provider to be gender competent. From the highest level of the health system, ministries and HRH professionals can use this competency framework to enhance or add gender dimensions to cadre- or program-specific competency frameworks. 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.

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 (Bloom, et al., 1956). 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:
Defining and Advancing Gender-Competent Family Planning Service Providers

1. 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.

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

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

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).

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<th>Competency</th>
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<td>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.</td>
<td>a. Aware of the power differentials that may exist because of gender, culture, education, or other differences and that impact access to information and services.</td>
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<td>b. Provides information to clients to obtain FP services, regardless of barriers created by the client’s gender, including literacy, access to media and technology, and ability to attend counseling.</td>
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<td>c. Maintains relaxed, friendly, and attentive body postures and eye contact, as appropriate, to show respect for the client, regardless of gender.</td>
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<td>d. Recognizes the effects of his/her own gender and power as a provider and the potential for bias to interfere with the provision of FP services.</td>
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<td>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.</td>
<td>a. Aware of the process of client obtaining his/her method of choice including accessibility and potential barriers and discusses the feasibility with the client, especially where one sex is disproportionately disadvantaged.</td>
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<td>b. Understands the varied reasons for method choice, including efficacy, longevity, accessibility, and tolerance of side effects that may vary by sex, gender, age, and safety and discusses these issues with clients.</td>
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<td>c. Understands the barriers and preferences of individuals, dependent on sex and gender, to access, choose, use, and continue to use FP services and proactively works to increase reproductive agency.</td>
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<td>d. Understands the economic, social, and physical factors that increase unwanted pregnancy and the choice to be sexually active based on gender, and proactively addresses these issues with clients.</td>
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<td>e. Discusses safe sexual practices that may be applicable to the client’s gender, including (as locally applicable) multiple partners, same-sex partners, unprotected sexual relations, and nonconsensual sex, such as marital rape.</td>
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<td>f. Encourages all clients to make their own informed and voluntary reproductive choices regardless of gender, age, relationship status, or consent by family members and consistent with national FP/RH policy.</td>
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<td>g. Acknowledges that the client has a right to make the final decision about using or not using FP and method choice.</td>
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<td>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 based on the client’s sex, age, or relationship status.</td>
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<td>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.</td>
<td>a. Understands and reinforces the client’s individual rights related to FP services and decisions to use contraceptive methods or not.</td>
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<td>b. Helps the client understand his/her rights related to FP services and offers information on a full range of method options regardless of gender, sexual orientation, relationship status, age, or occupation.</td>
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<td>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 sex.</td>
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<td>d. Provides equitable information, treatment, and services to all clients regardless of the type of relationship.</td>
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<td>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.</td>
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<td>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.</td>
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<td>5. Facilitating Positive Couples’ Communication and Cooperative Decision-Making refers to the provider’s capacity to help clients articulate, discuss, and negotiate reproductive intentions and to make joint reproductive decisions as a couple.</td>
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<td>6. Addressing Gender-Based Violence (GBV) refers to the provider’s ability to respond to GBV through brief empathetic counseling, safety planning, and appropriate referrals.</td>
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Next Steps

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. For example, the types of health cadres and their responsibilities are different in each health system. Moreover, in one context a health system may have more or fewer resources for training programs than another. There are also nuances in RH and FP in different contexts. For example, if female genital mutilation/cutting is practiced in a certain context, the framework should therefore be adjusted accordingly to ensure the provider is prompting with questions around female genital mutilation/cutting to demonstrate competency under the domain of Promoting Individual Agency.

As a next step, HRH2030 will field test the Gender Competency Framework for Family Planning Service Providers to determine whether the competencies are logical and understandable. This will also be an opportunity to consider diverse examples of application of the competencies across different contexts. HRH2030 will conduct key informant interviews, surveys, and facilitated debriefings with FP service providers in at least two different country contexts. The key informant interview questions and provider-level surveys will be adapted from the Gender Competency Framework for Family Planning Service Providers to assess the framework.

Using the information obtained from the field test, HRH2030 will incorporate any resulting recommendations into the Gender Competency Framework for Family Planning Service Providers, identify needs for capacity building to address the most salient gaps in gender competency, and contribute to the development of future training modules. The objective of this work is to effectively develop a gender-competent FP workforce by ensuring that relevant stakeholders have the tools needed to increase gender competency among FP service providers, thereby enabling women’s, men’s, and couples’ informed RH decisions, improved access to and use of FP, and greater gender equality.
Annex A. Glossary

**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.

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

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.

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