



# Resources and Training Models to Strengthen the Gender Competency of Family Planning Providers

A case example from Ghana comparing in-person, blended, and virtual training

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## Abstract

Gender competency refers to the knowledge, attitudes, and skills that family planning (FP) providers need to acquire and use to help clients overcome gender-related barriers to achieving their reproductive health goals. The United States Agency for International Development (USAID) supported the development of a provider self-assessment tool and eLearning course that can be used in trainings to strengthen gender competency among FP providers. This activity explored how to design trainings using these resources to inform future trainings conducted by the Ghana Health Services (GHS) Division of Family Planning, and as a model for other similar contexts. FP providers participated in three training modalities: in-person (n=14, Tamale, Northern region), blended (n=14, Kumasi, Ashanti region), and virtual (n=26, nationwide). Feedback was gathered through surveys and group discussions. While all providers in the in-person and blended modalities completed the eLearning course, only 65% of virtual participants did so. Higher levels of peer-to-peer engagement in the in-person and blended formats may have increased accountability and helped contextualize global content to the local setting. The virtual training offered flexibility and broader access, but poor internet connectivity was a significant barrier, requiring some participants to complete the training during their off-hours or travel to areas with better connectivity. Provider self-assessment tool scores increased after taking the eLearning course for all three training modalities. Future training using these resources should be tailored based on providers' internet access, digital literacy, and preference.

## Positionality Statements

**Katherine Andrinopoulos:** I am a cisgender woman and mother of two children. I work for a large private university in the United States. I have always had easy access to family planning. My Greek Orthodox Christian faith is balanced by my critical feminist beliefs. These traits influence my personal beliefs about gender construction and the importance of freedom in decision making about marriage and family planning. As a researcher, my experience is limited compared to family planning providers who serve clients directly, and who live and work in contexts with greater differences in power between women and men. I attend to these differences by reflecting on my assumptions when interpreting data and presenting findings.

**Janna Wisniewski:** I am a White feminist woman working in a private university in the United States. My perspective is informed by a commitment to equity, empowerment, and justice for all genders, while acknowledging that my experiences provide me with specific insights but also limit my understanding of the lived realities of other communities globally. I strive to engage with others to ensure my research is grounded in the contexts and experiences of the populations it seeks to serve.

**Evelyn Koko:** As a market and social researcher, I have worked on various family planning-related studies that have not only honed my expertise but also shaped my beliefs and attitudes towards this critical aspect of public health. Growing up in Ghana, I have witnessed how cultural norms often place the burden of family planning solely on women. This societal expectation has profoundly influenced my own beliefs and attitudes towards family planning, and I recognize that it may have implicitly biased my approach to research in this field. However, through my work on this family planning training program, I have come to realize the importance of engaging both men and women in the family planning process. I am eager to challenge my own assumptions and biases, and to explore innovative strategies for promoting gender-inclusive family planning practices.

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## Cover

Healthcare provider in Ghana Explaining Services to Clients © 2021 Emmanuel Attramah, PMI Impact Malaria Ghana

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## Abbreviations

FP	Family planning
GBV	Gender based violence
GHS	Ghana Health Services
HRH 2030	Human Resources for Health
IT	Information technology
PRH	Population and Reproductive Health
USAID	United States Agency for International Development

## Executive Summary

Gender competency encompasses the knowledge, attitudes, and skills that family planning (FP) providers need to help clients navigate the influence of gender on their FP choices. Given the importance of addressing gender in the context of FP services, the United States Agency for International Development (USAID) Population and Reproductive Health (PRH) Gender Team supported a series of projects to develop a suite of resources that can be used to help FP providers address the gender-related barriers faced by their clients. This began with the development of the “Gender Competency Framework for Family Planning Providers” by the Human Resource for Health 2030 Project (USAID and HRH2030, 2018), which outlines six domains of gender competency critical to FP service delivery that include:

1. Gender-sensitive communication
2. Promoting individual agency
3. Supporting legal rights and status related to family planning
4. Engaging men and boys as partners and users
5. Facilitating couples’ positive communication and cooperative decision-making
6. Addressing gender-based violence

Using this framework, USAID supported the development of training resources to strengthen the gender competency of FP providers, including a provider self-assessment tool and an eLearning course. These can be used by government ministries, foundations, non-governmental organizations, and individual providers in the training, supportive supervision, quality improvement, and other learning opportunities for FP providers to strengthen their gender competency.

The purpose of this activity was to demonstrate how the gender competency tool and eLearning course can be applied to train providers in a real-world setting, specifically a national FP program in Ghana. In so doing, we examine provider perspectives on the content of the tool and eLearning course, as well as the logistical aspects of delivering training using online resources. In recent years, there has been a vast proliferation of online educational resources developed for global health programs. This activity provides an in-depth exploration of how to design gender competency trainings using the gender competency self-assessment tool and eLearning course.

Trainings were conducted using in-person (Tamale, Northern region, n=14 providers), blended (Kumasi, Ashanti region, n=14), and virtual (all 16 regions nationwide, n= 26) modalities. Providers completed the self-assessment tool before and after the eLearning course. They also completed surveys about the usability of the tool and the content of the eLearning modules, including whether they liked the content, the relevancy of the content to their work, and their opinion about using this content in future training. Group discussions were held using a semi-structured guide to elicit provider feedback on the content, how the resources could be used in trainings for FP providers, and the strengths and drawbacks of in-person, blended, and virtual modalities. Small and large group discussions were audio recorded, transcribed, and summarized in relation to each case study question. Data on eLearning course completion was extracted from the online platform and provided to the activity team. Frequencies were calculated for survey responses. Chi-squared tests of association were conducted to assess differences in course completion rates by provider demographics and differences in self-assessment tool scores pre vs. post eLearning course completion.



## Key Findings

- Providers liked the content, felt that it was relevant to their work, and reported that they would be interested in additional training.
- The domains related to “engaging men and boys as partners and users” and “addressing GBV” were noted as the most important domains in Ghana. Providers explained that increasing male engagement was a constant challenge and could have an important impact on FP uptake and continuation. Providers also felt that GBV was an important issue faced by their clients and that it was important for providers to know how to address GBV and where they can refer clients for additional services in this area.
- All providers in the in-person and blended training modalities completed the eLearning course, but only 65% of providers in the virtual training did so.
- Device type (personal smartphone vs. loaned tablet) and extra text message reminders (in addition to the standard messages sent to complete the course) did not impact course completion.
- The blended and virtual training required providers to complete most of the eLearning course asynchronously in the week between group meetings. For asynchronous work, most modules were completed during the providers’ off-hours (67%). Fewer were completed during work hours (19%) or during both off-hours and during work (14%).
- The primary reason for completing modules during off-hours was increased internet strength in the evenings. Some providers remained at their work facilities during off-hours to access stronger internet or traveled to other communities to obtain better internet access.
- Gender competency tool scores were higher after completion of the eLearning course.
- Strengths of the in-person training modality were that it fostered peer-to-peer engagement. This engagement helped providers contextualize the global content more specifically for their local context, and to develop actionable next steps based on shared experiences. In-person training allowed for uninterrupted focus on the course content. Drawbacks included the stress and cost of travel and the fixed time for completion of course modules.
- Strengths of the blended format included peer-to-peer engagement and technological support to help providers access the eLearning course and get accustomed to logging in and out of modules. Drawbacks included having to travel and difficulty in recalling nuanced information about course content completed asynchronously during face-to-face group discussions. Poor internet network connectivity made it challenging to complete asynchronous work within a week for some participants.
- Strengths of the virtual training format included increased access to more providers, less travel, and increased convenience since providers could complete modules intermittently between other work and personal tasks. Drawbacks included limited peer-to-peer engagement, lower completion rates, and difficulty accessing the course because of poor internet networks requiring completion at work facilities or travel to communities with stronger networks.

Based on these findings, it is recommended that the gender competency tool and eLearning course be used together in structured trainings. This will likely be more effective compared to simply sharing the links to these resources and asking them to complete them on their own. Rather than a “one size fits all” approach, the training modality (in-person, blended, virtual) should be tailored to the audience. Factors that should be considered include the resources available as well as internet connectivity, provider preference, and digital literacy. The most critical factor to consider is internet connectivity, which is required to download the self-assessment tool and to stream the eLearning course. The positive findings in this exploratory case study suggest that further research on the effectiveness of training using the self-assessment tool and eLearning course to increase FP providers’ gender competency is warranted. Additional research is also warranted to better understand the sustainability of different training modalities and to conduct a cost analysis of training using these resources.

For teams planning to implement training, it is recommended that they provide training participants with approximately 5 GB of network data if funding is available to do so. Each provider will also need a device to access the eLearning course, which can be a smartphone, tablet, or computer. In terms of implementation team members, it is recommended that one person with expertise in gender competency and FP moderate the training, and that an IT specialist is also available to support providers.

It is recommended that an incentive be provided to participants to complete the course. This may be monetary but can also be in the form of continuing professional development credits, or other educational credits if used as part of the nursing or pre-service curriculum. Certificates can also serve as a form of provider incentive. Finally, for in-person and blended training, implementation teams should consider reimbursement of transportation costs. Alternatively, in-person and blended training could be conducted at a healthcare facility or nearby facilities so that the implementation team travels to the site rather than providers traveling to a different location.

Structured training should cultivate provider peer-to-peer engagement based on the material in the gender competency tool and eLearning course. As a starting point, questions from the self-assessment tool discussion guide can be used to facilitate the discussion. This engagement will help providers contextualize the global materials so that concrete next steps in their local environments are identified. For in-person trainings, providers could set up a group chat via WhatsApp or similar text messaging service, so that providers can continue to engage after the training as they apply the gender-related skills in their work. For the blended and virtual training, remote coaching from a moderator and group chats should be included during the asynchronous work to enhance engagement and promote accountability in completing the course.

These recommendations should be weighed against available funds and implementation team capacity for the training. However, many recommendations can be implemented at low cost with advance planning and ongoing structured support from leadership. The gender competency self-assessment tool and eLearning course are important resources. They include content developed with global input that providers in Ghana find important and relevant to their work. Wider application of these resources through in-person, blended, and virtual trainings can help FP providers strengthen their gender competency and improve FP services.

## Background

Gender shapes the family planning (FP) choices of clients in many ways. Access to information, decision-making power, societal expectations, and availability of contraceptive methods are just a few examples of factors influenced by gender that also affect FP services. Gender competency encompasses the knowledge, attitudes, and skills that FP providers need to help clients navigate the influence of gender on their FP choices. With increased gender competency, providers can deliver higher-quality FP services.

Given the importance of addressing gender in the context of FP services, the United States Agency for International Development (USAID) Population and Reproductive Health (PRH) Gender Team supported a series of projects to develop a suite of resources that can be used to help FP providers address the gender-related barriers faced by their clients. This began with the development of the “Gender Competency Framework for Family Planning Providers” by the Human Resource for Health 2030 Project (USAID and HRH2030, 2018), which outlines six domains of gender competency critical to FP service delivery that include:

1. Gender-sensitive communication
2. Promoting individual agency
3. Supporting legal rights and status related to family planning
4. Engaging men and boys as partners and users
5. Facilitating couples’ positive communication and cooperative decision-making
6. Addressing gender-based violence

The framework was developed based on formative research conducted in Ethiopia and the Philippines with FP providers, as well as FP expert review meetings. The framework defines gender as “the economic, social, political, and cultural attributes, constraints, and opportunities associated with being male or female in a society. Gender includes the roles, behaviors, activities, rights, and responsibilities that a society considers appropriate for women, men, girls, and boys” (USAID and HRH2030, 2018).

Using this framework, USAID supported the development of training resources to strengthen the gender competency of FP providers in each domain, including a self-assessment tool and an eLearning course. These can be used by government ministries, foundations, non-governmental organizations, and individual providers in the training, supportive supervision, quality improvement, and other learning opportunities for FP providers to strengthen their gender competency. The tool and eLearning course are designed as global resources appropriate across international contexts and are free and publicly available via the Data for Impact and Chemonics websites as follows:

- Gender competency provider self-assessment tool:  
<https://www.data4impactproject.org/publications/gender-competency-tool-guidance/>
- Gender competency eLearning course:  
<https://chemonics.com/resource/defining-and-advancing-gender-competent-family-planning-service-providers/>

## **Self-Assessment Tool to Measure Family Planning Provider’s Gender Competency**

The gender competency self-assessment tool includes six modules, each related to one domain of gender competency. By completing the tool, providers gain a quantitative assessment of their gender competency also learn about the knowledge, attitudes, and skills important in each area. This assessment helps providers better understand their gender competency strengths and weaknesses and where additional training is needed. The assessment tool can be used to measure competency in one domain or as a full assessment of all six domains. The complete tool includes 71 items. Individual modules range in items from 7–15 and require between 8–19 minutes to complete.

There are three parts to each tool module: a statement and response form, answer key, and discussion guide. The statement and response form includes closed-ended questions with 4-point Likert scale responses (strongly agree – strongly disagree). Next, providers use the answer key to assign a point value to their responses, sum their score, and determine whether the score falls within the range of low, medium, or high gender competency. The final component of each module is a discussion guide that explains the concepts presented by items. The guide also includes self-reflection questions and a discussion guide that can be used by teams of providers completing the training together. These questions are specific to each domain, elicit the collective experiences of FP providers, and promote the sharing of solutions related to the gender and FP issue presented in the module. Details about the tool development are described in the tool instruction guide (Andrinopoulos et al., 2023a). Feedback about the acceptability and usability of the tool from FP providers in Ghana is presented in the webinar “A Tool to Measure the Gender Competency of Family Planning Providers” (Andrinopoulos et al., 2023b).

## **eLearning Course on Gender Competency for Family Planning Providers**

The gender competency eLearning course includes seven didactic modules covering information about gender, power, and the six gender competency domains. The course also has a final knowledge assessment, which, if passed, produces a personalized certificate of completion. Within each didactic module, educational content is presented via streamed videos interspersed with interactive learning elements (e.g., multiple-choice questions and responses, clinical case examples) to foster active learning and skill building. The content demonstrates how to apply gender competency skills in common service delivery situations. It uses global images to represent potential users from around the world.

The training is designed so that it can be accessed by individual FP providers and completed in a self-paced format. To access the course, providers enter their name and email address on the website. Using these credentials, the providers launch the course. They can exit modules and resume modules at a later time as needed. Each module can be completed in approximately 25–40 minutes if run without interruption. The course is device-adaptive and can be completed via computer, tablet, and smartphone. With the exception of the certificate of completion, the material cannot be downloaded and must be streamed.

## Case Study Report Purpose and Questions

The purpose of this activity was to demonstrate how the gender competency tool and eLearning course can be applied to train providers in a real-world setting, specifically a national FP program. In so doing, we examine provider perspectives on the content of the tool and eLearning course, as well as the logistical aspects of delivering training using online resources. In recent years, there has been a vast proliferation of online educational resources developed for global health programs and an increase in virtual meetings and webinars. The potential advantages of the online space include increased reach and affordability. However, there are also potential limitations related to internet connectivity, device availability, and provider technological abilities that could hamper online learning experiences. An in-depth exploration of these issues was conducted to serve as an example of how the gender competency tool and eLearning course might be utilized via in-person, blended, and virtual formats.

This case study was planned and conducted in collaboration with the Ghana Health Services (GHS) Division of Family Planning. The GHS was a key partner in the development and piloting of the provider self-assessment tool. Accordingly, the GHS expressed an interest in using the tool and eLearning course to train FP providers nationwide. This activity was planned to inform their efforts to integrate gender competency training into their ongoing training of in-service FP providers. Recently, the GHS launched the GHS eLearning platform <https://ghsvirtualplatform.com/> with the stated goal of using eLearning “to complement in-person training for the health workforce...without disrupting routine health service delivery.” As such, this activity serves to inform factors important to the success of eLearning more broadly in Ghana and elsewhere.

Through this project, we sought to answer the following questions:

1. Do FP providers in Ghana find the content of the gender competency self-assessment tool and eLearning course to be acceptable, relevant, and useful to their work?
2. What are the strengths and drawbacks of delivering gender competency training via in-person, blended, and virtual modalities using the self-assessment tool and eLearning course?
3. What are the resource needs for implementing in-person, blended, and virtual gender competency training?

## Methods and Limitations

Gender competency trainings using in-person, blended, and virtual modalities were conducted between December 2023 and May 2024. The in-person training was held in the city of Tamale in the Northern Region, the blended workshop was held in the city of Kumasi in the Ashanti Region, and the virtual trainings included providers from all 16 administrative regions of Ghana. The GHS Division of Family Planning and the GHS Regional Directorate developed lists of providers invited to each training. The lists were developed to ensure that diversity in provider cadre and sex were captured in each training modality. Invitations were sent to providers from the GHS Regional Directorate and to their health facility in-charge to approve participation in the trainings.

The training implementation teams were comprised of a moderator with expertise in gender, health training, and qualitative research, two personnel for registration and logistical support, and an information technology (IT) specialist. In-person and most blended workshop participants were loaned a

tablet by the implementation team. In the blended training, a subset of four providers were randomly assigned to use their own smartphones, and another four were randomly assigned to receive additional WhatsApp message reminders beyond those provided to the wider group.

### **In-Person Training**

The in-person workshop was conducted over two consecutive days in a centrally located meeting room. Providers completed a short registration survey eliciting demographic and cadre information. Next, they completed the provider self-assessment tool. For the purposes of the demonstration project, the tool was delivered via a Qualtrics survey instead of the paper-based format, thereby allowing the team to access the quantitative results for a pre/post analysis. At the completion of the self-assessment tool, providers were asked to complete a 5-item usability survey adapted from the System Usability Scale (Brooke, 1996) and an open-ended text question to provide their opinion about the tool.

Next, participants created online accounts for the eLearning course and completed the modules. After each module, they completed a survey with 8 items eliciting whether they liked the content, the relevancy of the content to their work, and their opinion about using this content in future training for themselves and other providers. The survey also included an open-ended text question to provide their opinion. After the feedback survey, providers were divided into two groups of seven participants for a group discussion about the content. This was moderated by one team member while another documented detailed notes. Open-ended questions were derived from the self-assessment tool discussion guide. This process was repeated after each module.

Once the eLearning course was complete, providers completed the self-assessment tool again. At the conclusion of the two-day period, a large group discussion was held using a semi-structured guide that asked participants their opinion about how the resources could be used in trainings for FP providers and the strengths and drawbacks of in-person, blended, and virtual modalities. Small and large group discussions were audio recorded and transcribed.

### **Blended Training**

The blended training followed a similar process. Providers were invited to a central meeting place for two half-day sessions held one week apart. The first session included registration, self-assessment tool completion, tool feedback survey, completion of modules 1–3 of the eLearning course, course module feedback survey, and small group discussion. Participants were asked if they wanted to be added to a WhatsApp group message to receive reminders about the course, and links to the eLearning course and feedback surveys. Tablets were also loaded with a document with links and matching QR codes for the eLearning course and feedback surveys for each module. A test message was sent to providers, and they were encouraged to contact the team’s technology specialist if they encountered any problems (also present at the meeting). They were then instructed to complete the remaining eLearning course modules on their own (asynchronously) throughout the week. Providers were sent a message via email and WhatsApp text message reminding them to complete the course and providing the necessary internet links.

During the second day, providers completed the self-assessment tool again. Next, small group discussions (seven participants each) were held about the content of the training modules and a large group discussion about future training and the in-person, blended, and virtual modalities.

## Virtual Training

The virtual training consisted of two hourlong virtual meetings held on Zoom one week apart. During the first meeting, a facilitator explained the self-assessment tool, eLearning course, and feedback surveys. Providers were asked if they would like to be connected via a WhatsApp group. They were introduced to the technology specialist and encouraged to contact them with any problems. After the meeting, participants were sent links to the tool, course, and surveys via email and WhatsApp, and a reminder to complete the tool and eLearning course before the next meeting.

During the second Zoom meeting, providers were assigned to breakout rooms (approximately 7–10 providers per room). A moderator facilitated a condensed version of the small and large group discussion guide to elicit feedback on the module contents and different modes of training delivery.

Across all formats, participants were provided 5 GB of data so that they could complete the self-assessment tool online, as well as the feedback surveys and eLearning course. Providers in the in-person and blended training were remunerated \$400.00 Ghanaian Cedi equivalent to US\$26.00, and those in the virtual meetings were remunerated \$300.00 Ghanaian Cedi equivalent to US\$20.00 for completing the self-assessment tool twice and providing feedback on the resources. Those in the in-person and blended trainings were also reimbursed for transportation.

The eLearning course completion data was extracted from the online course platform and provided by Chemonics. The course was considered complete when all modules were viewed, and the provider achieved a passing score on the embedded final knowledge assessment.

The sample size for this exploratory project was selected to mirror a typical training session for each modality and based on the team's capacity to facilitate the training and collect feedback. Analysis of the quantitative data focuses primarily on univariate frequencies. Bivariate associations were assessed for differences in eLearning course completion rates and demographic attributes using chi-squared tests. Differences in self-assessment tool scores were also assessed using chi-squared tests comparing scores pre vs. post eLearning course completion. Scores for each module and the total aggregate score were analyzed. Qualitative data were transcribed and summarized to identify salient perspectives on the tool and course content, key strengths and weaknesses of each training modality, and overall recommendations for future training. For all analyses, findings were compared across female and male providers.

The protocol for this project was reviewed by the Tulane University Biomedical Institutional Review Board, which deemed it to be non-human subjects. It was also reviewed by the University of Ghana ethics board, which approved it as a follow-on to the original project to develop the self-assessment tool.

## Limitations

While the trainings were designed to yield in-depth quantitative and qualitative feedback, several limitations should be noted. The data is descriptive and exploratory and is not powered to determine quantitative differences between groups. There may be selection bias resulting from the recruitment of providers through the GHS invitations. There may also be social desirability bias in provider feedback, leading to more positive responses as participants were informed that the GHS intends to apply this training in the future. The self-assessment tool is designed to promote provider learning and explains why some answers are considered more gender competent. While it is plausible to attribute changes in

provider scores to the eLearning course, it is also possible that these changes would occur with repeat use of the tool alone. Nevertheless, the feedback documented through quantitative and qualitative data, in addition to the experience implementing pilot trainings, provides descriptive information that advances understanding about how to design future gender competency trainings.

## Results

A total of 52 family planning providers participated in the trainings, with two providers participating in both the in-person and virtual training sessions (in-person n=14, blended n=14, virtual n=26). Table 1 summarizes the demographic profile of participants. Most of the participants were female (76%). The majority were 35–44 years of age (57%). The trainings included a diverse cadre of FP providers with the majority being nurses (45%), followed by midwives (25%), physicians (13%), community health workers (11%) and other (6%). Slightly more than half held management positions (59%).

**Table 1. Demographic Background of Family Planning Providers Participating in Gender Competency Trainings in Ghana, December to May 2024 (N=54)**

	In-person training (n=14)	Blended training (n=14)	Virtual training (n=26)	Total (N=54) No. (%)
<b>Gender</b>				
Female	10	10	21	41 (76%)
Male	4	4	5	13 (24%)
<b>Age<sup>^</sup></b>				
25–34	5	6	6	17 (32%)
35–44	8	8	14	30 (57%)
45–54	1	0	3	4 (8%)
55–64	0	0	2	2 (4%)
<b>Provider cadre<sup>^</sup></b>				
Nurse	5	6	13	24 (45%)
Midwife	4	3	6	13 (25%)
Physician	2	2	3	7 (13%)
Community health worker	2	3	1	6 (11%)
Other	1	0	2	3 (6%)
<b>Management position<sup>^^</sup></b>				
Yes	4	10	16	30 (59%)
No	10	4	7	21 (41%)
<sup>^</sup> One missing value for virtual participants; <sup>^^</sup> Three missing values for virtual participants. Percentage totals may be > 100 due to rounding.				



## Provider Perspectives on Training Content

The training content was well received by participants for all six gender competency domains. Participants reported that they liked the content, that it was relevant to their work, and that they would be interested in further additional training (see tables in [Appendix 1](#)). They also rated the tool as easy to use. This was confirmed through both the survey responses and open-ended questions. It was true for both female and male providers and across training modalities.

Each domain was selected as the most important by at least one or more participants. However, the domains most often identified as most important were those focused on “engaging men and boys as partners and users” and “addressing GBV.”

In terms of engaging men and boys, several providers noted that a lack of male engagement was one of their biggest challenges to service delivery. Designing programs to reach men was noted as an important problem. As one participant explained:

*“In our line of work that has always been our main hinderance to coverage, to reaching our targets in family planning targets. The men have always been our main hinderance to that.”*

—Female provider, in-person training

Beyond meeting targets, engaging men and boys was valued for the positive influence it could have on female clients. Providers agreed that having a supportive and engaged partner was helpful to their female clients in reaching their FP goals. Increased awareness and accuracy in understanding contraceptive methods among men was seen as important for uptake and method continuation. For example, one provider explained:

*“We should encourage the men to be positively involved in family planning. This is because most times some of them have some myths and misconceptions surrounding some methods and that’s how they turn to discourage their partners or themselves from partaking in such procedures.”*

—Female provider, blended training

Providers appreciated the examples provided in the training about how to discuss FP with men and boys, and how to address some of the common concerns and misconceptions they hold about FP and contraception. Yet providers still struggled with practical aspects about how to do this.

In terms of GBV, several participants noted that they weren’t aware that identifying GBV was a part of FP service provision prior to the training but agreed that this is important to their work. Providers’ experiences with clients aligned with the messaging in this module about how FP choices can be influenced by GBV (for example, method discontinuation) and how different types of contraception can put a woman at risk for GBV. One provider explained the importance of what they learned as follows:

*“With these modules we got into understand clients go through violence because of certain services. Gender based violence can lead to people giving up the [contraceptive] method. “*

—Male provider, in-person training

The “do no harm” principle explained in the training content also resonated with providers. These providers agreed that FP providers can play an important role in identifying people experiencing GBV and

appreciated the important of making referrals rather than attempting to provide specialized GBV counseling themselves. As one provider explained:

*“With the gender-based violence, when I used to get a case like that, I struggled to attend to the client, but this module has taught me to refer to a trained personnel to handle that issue.”*

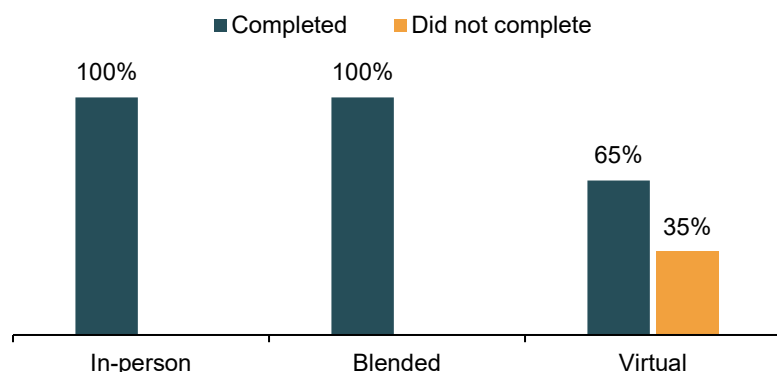
—Female provider, in-person training

Several participants expressed a desire for more information about referral resources for GBV services in their area. Participants also suggested that having a local resource list for GBV referral, as well as information about relevant laws and policies related to FP in their area, would be helpful.

### Training Modality Completion Rates

All providers in the in-person and blended training modalities completed the eLearning course and passed the embedded knowledge assessment. In contrast, only 65% of the virtual learners did so (Figure 1). Among the virtual learners, there were no differences in completion rate by sex, age, cadre, years working in FP, location (Accra versus other), or mode of completion (phone versus tablet) that were detected.<sup>1</sup>

**Figure 1. Percent of providers who completed the gender competency eLearning course by training modality, December to May 2024 (N=54)**

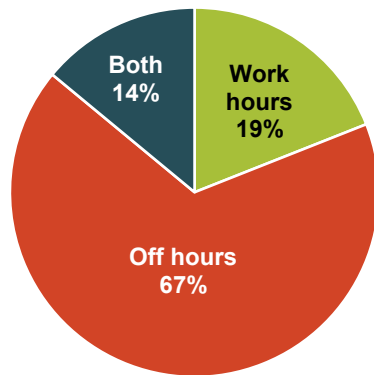


During the blended workshop, a subset of four participants was asked to use their own personal smartphone to complete the training instead of tablets provided by the implementation team. Another subset of providers received extra WhatsApp message reminders to complete the modules beyond those sent to the wider group. Ultimately, all the providers in the blended workshop completed the trainings, demonstrating no difference in completion by device type or frequency in message reminders.

To better understand factors that might influence course completion, participants in the blended and virtual trainings were asked to report when they completed the eLearning course. Most of the modules were completed during off-hours (67%). Fewer were completed during work hours (19%) or during both off-hours and at work (14%).

<sup>1</sup> This descriptive assessment was not powered to detect differences in these variables and course completion. Results should be considered exploratory.

**Figure 2. Percent of gender competency eLearning course modules during work hours, off hours, or both; December to May 2024 (N=57 modules)**

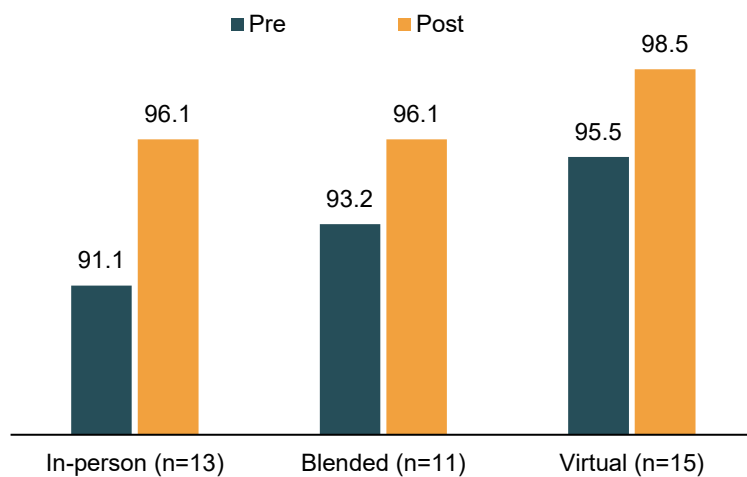


Provider decisions about when to complete the training were largely driven by their ability to access internet connectivity. Several providers noted stronger internet at their healthcare facility. Many completed during off-hours in the evening because fewer people were on the network. Some stayed at their facility to do so. Other providers who completed modules during their off-hours explained that there were fewer distractions at home in the evening than at work. A few participants noted being accustomed to studying at night in general, and so a preference for off-hour completion of modules.

### Comparison of Self-Assessment Scores Pre/Post eLearning Course

Among providers who completed the eLearning course, there was a statistically significant increase in their total score on the self-assessment tool (see Figure 3). This was also true when scores were examined by individual domains, with the exception of the one focused on “supporting legal rights and status related to family planning.”

**Figure 3. Comparison of provider gender competency self-assessment scores pre and post eLearning course completion by training modality, December to May 2024**



\*Self-assessment score differences were statistically significant at the p<.001 level for each modality.

## Provider Perspectives on Training Modalities

While subsets of participants had clear personal preferences for in-person versus blended/virtual trainings, the consensus across participants was that the training modality should depend on the resources, internet network access, learning style preferences, and the digital literacy of the providers.

### In-Person Training Benefits and Drawbacks

According to providers, the main benefit of in-person training was that it fostered peer engagement with other FP providers through face-to-face communication. During the in-person training, the discussions held after each course module provided a space for providers to share common challenges that they experienced related to the gender domains covered by the training. It also allowed them to share ideas about how to address the issues discussed in each module and how they related specifically to the context in Ghana. Through the conversations fostered by face-to-face engagement, providers shared experiences about the complexity they encounter in their day-to-day work related to gender and FP service provision. As one provider explained:

*“As we usually finish our individual assessment and then [the] eLearning course, and we discuss our different views, I would share and discuss and that is a learning process. If not, I wouldn’t have heard some stories.”*

—Female provider, in-person training

Another major benefit of the in-person training modality was that it allowed providers to focus on the content without distraction from other work and personal responsibilities. Participants had the space and devices needed to complete the training, uninterrupted time to devote to the content, and external accountability of the facilitators and other providers to complete the content. One participant described this as follows:

*“The fact that we are here for this purpose, everyone is concentrating on that one purpose, because that is why we are here. As compared to if I was to be in my house, after all there is no one to guide me [there], I am not under obligation.”*

—Male provider, in-person training

Several participants noted that in-person training was especially beneficial for providers who may have a lower level of digital literacy and comfort with online educational platforms. Participants described some providers who were “not into technology” because they prefer in-person interpersonal communication and interaction rather than asynchronous and online interactions. They also described a different group to be those “born before technology.” These providers are more comfortable with in-person training because they were exposed to technology and online educational tools later in life and are less accustomed to using them. For both groups, in-person training facilitated better engagement with the training content. Onsite technology support was also perceived as helpful to troubleshoot any issues with the online platform.

Providers noted the main drawbacks of the in-person modality to be the travel it required as well as the overall additional cost to the group implementing the training, including space rental, food, and transportation. Transportation was noted as both costly to implementers and potentially inconvenient to participants. An additional weakness noted was that the in-person agenda required participants to

complete modules within a specific time. Some providers needed more time to complete modules either because they required a slower pace to study the content or because of internet connectivity issues that delayed the streaming of eLearning content. Despite the in-person training being held in a meeting space with internet connectivity and the use of a back-up modem provided by the implementation team, there were still buffering issues related to the speed of the network, which meant that some providers finished modules earlier than others.

### Blended Training Benefits and Drawbacks

Participants noted similar benefits for the blended training as they did for the in-person training, including enhanced peer engagement and technical support. By meeting in person with providers before they attempted the online and asynchronous work, the implementation team was able to ensure seamless registration and login to the eLearning course. They were also available to providers as they worked through the first module and could troubleshoot any questions related to navigating the course. As one provider noted:

*“Peer-to-peer support will help in the case of the online platform or getting a technical person to help when the need arises.”*

—Female provider, blended training

Providers in the blended training also appreciated the opportunity to discuss module content with other providers in a face-to-face format. For example, one provider noted:

*“I think the blended is better because you tend to get more insight through the discussions that may come up.”*

—Female provider, blended training

At the same time, the implementation team noted that it was more difficult to facilitate discussions about specific module content in the blended versus fully in-person format. This was attributed to providers having to recall information about specific module content that they had completed during the previous week rather than holding discussions immediately after module completion. Given the connectedness of module content, it was difficult for providers to remember the nuanced information specific to each module rather than discussing the content from all modules together.

Like the in-person training, drawbacks for the blended modality included transportation and cost. All providers in the blended training completed the eLearning course. However, in their reflections about this type of training modality, several providers noted that internet connectivity could make it difficult to complete the training during the week between sessions.

### Virtual Training Benefits and Drawbacks

Providers explained several unique strengths to the virtual training modality compared to in-person and blended trainings, primarily lower cost for implementation and increased access. By eliminating travel to a training site, providers noted that virtual trainings open up learning to a wider group of providers rather than only a select few providers that could be sent to trainings from each facility. One provider explained this as follows:

*“It also helps to reduce selection bias of staff. Because certain times there are just some particular people who attend workshops while other people don’t get the opportunity to attend. But if it is eLearning, I pick my smartphone, I go onto it, get my knowledge and get my certificate, so a lot of people will be enrolled.”*

—Female provider, in-person training

Several providers noted that the stress associated with travel, especially from rural areas, was eliminated with virtual training. Some providers also felt that virtual training was more convenient because it allowed them to study the content intermittently between other work or personal tasks rather than having to dedicate a single block of time to the activity. As one provider explained, they felt strongly that eLearning is the future because of these conveniences.

*“We have to motivate ourselves that this [virtual] process way of training is even cost effective...there are times you go to face-to-face workshops...then you frown your face because you have moved a long distance...and nothing is being given. But with this eLearning...I can just sit at my far away distance and I have network, and I'm able to learn what I would have moved so many miles to go and learn. I think this is a good way. So everybody, should get motivated to know that eLearning it's kind of less stressful, and the best for us in the setting in Ghana.”*

—Female provider, virtual training

The principal drawback to the virtual training was the limited internet network, which prevented access to course material. Buffering of material or having to stop and restart modules because of network issues was described as frustrating. In some cases, participants traveled to locations with a steady and strong network to complete the eLearning course. As one provider explained:

*“With the virtual its good if you have network, but some of us have network challenge, so should we include those who also have that problem, because that person will not participate fully. My network is very bad. So face-to-face, that one we are together so learning can take place. But the problem with virtual is the network. If the network is fine, there is no problem. At a point I had network problems, so I have to move to another community, get the network, and sit down and work.”*

—Female provider, virtual training

As noted for the blended model, some participants chose to complete the modules late at night because that is when they could get the strongest internet signal. As one provider explained she:

*“...decided to do it [course] deep in the night because that is when I get the network cleared. I had access to it when the network was cleared around midnight and then I was able to work on it more. Right now, where I am currently having my Zoom meeting, I have to go to certain locations and really look for where to do it.”*

—Female provider, virtual training

Reflecting on these trainings and other virtual meetings they’ve attended, participants noted that many times there is background noise because people join meetings from public spaces. They also noted interruptions caused by people failing to mute or unmute to talk. These experiences made the discussion of content and learning from virtual meetings less productive and appealing to participants. Even without

these issues, some participants liked the interpersonal connection of being physically present for discussions with other providers. As one provider explained:

*“It’s the face-to-face that I’m used to and that’s what I enjoy.”*

—Female provider, virtual training

Overall, the three training modalities each brought unique strengths and drawbacks, that are summarized in Table 2.

**Table 2. Summary of provider perspectives on the benefits and drawbacks of in-person, blended, and virtual training modalities, in Ghana, December to May 2024 (N=52)**

Modality	Benefits	Drawbacks
In-person	<ul style="list-style-type: none"> <li>• Optimizes peer-learning</li> <li>• Supports team building and engagement</li> <li>• Sufficient protected time to complete training</li> </ul>	<ul style="list-style-type: none"> <li>• Higher cost</li> <li>• Requires transportation</li> <li>• Structured learning cadence</li> </ul>
Blended	<ul style="list-style-type: none"> <li>• Optimizes peer-learning</li> <li>• Supports team building and engagement,</li> <li>• Some protected time for training, flexible learning cadence</li> </ul>	<ul style="list-style-type: none"> <li>• Higher cost</li> <li>• Requires transportation</li> <li>• Internet network and technology dependent</li> </ul>
Virtual	<ul style="list-style-type: none"> <li>• More accessible to participants</li> <li>• Lower cost to implement</li> <li>• No transportation needs</li> <li>• Flexible learning cadence (providers can complete at their own speed)</li> </ul>	<ul style="list-style-type: none"> <li>• Highest risk of drop-out</li> <li>• Less engaging</li> <li>• Internet network and technology dependent</li> </ul>

### Crosscutting Feedback about Designing Trainings

In addition to specific feedback about training modalities, providers noted several factors that would increase the success of gender competency training using the self-assessment tool and eLearning course more generally. Providers noted that it was important for participants to be given internet network data bundles so that they could complete the eLearning course. At least 5 GB data bundles were needed. Participants noted that it is often overlooked that providers would need network data as a resource, despite increases in invitations to virtual meetings and online training. As one participant explained:

*“This is the first time that I’m given data to attend an eLearning or a Zoom meeting. There are other Zoom learning sessions...but I’m not able to join, because they just put the link there and said it’s supposed to be at this time, but because of data, as my sister said, most of us are not joining. But you gave us data, so it’s motivated us to actually strive to do it. Without data your zeal is low, but because of the data, you have to try and join.”*

—Female provider, virtual training

It is also important to include a technology expert on the implementation team. This role is critical to ensuring that participants can access the eLearning course and troubleshoot any issues they experience while completing the course. Participants had constant connection to a technology support person via WhatsApp for these trainings. Common issues resolved for participants included helping them with pop-up blockers and navigating glitches in test quizzes. One participant explained the importance of technology

support as follows:

*“I think they should add a resource person. Because no matter how much you know about the technology or the IT aspect, I think if there’s a resource person when you are stuck then you call for guidance... that would help a lot.”*

—Female provider, virtual training

Connecting blended and virtual training participants via WhatsApp also enabled peer support for technology issues. For both groups, there were several instances where providers wrote to the group chat with technology-related questions and received feedback from a group member in addition to the IT specialist.

While there was no difference noted in course completion by device type, several participants noted that it was harder to complete the course by phone compared to a tablet. In some cases, participants had trouble selecting a response or pushing the “next” button on the phone. The audio and video were also sometimes out of sync. However, this should be weighed against cost considerations given the expense of tablets and the potential difficulty of distributing and retrieving them from participants across geographic locations. Overall, the course could be completed effectively via smartphone, though participants might prefer to use a tablet or computer if one is available.

Providers also noted that it was important to provide additional motivation to support course completion. For the purposes of this pilot activity, participants were provided a monetary incentive for completing the self-assessment tool before and after the eLearning course. Other incentives suggested by providers included continuing professional development credits (which are required annually for FP providers in Ghana) and certificates. These could be provided in lieu of, or in addition to, monetary incentives, depending on the implementation team’s budget.

### **Materials and Other Resource Recommendations Based on Implementation Team Experience**

Materials needed to implement gender competency training are similar across training modalities (see Table 3). Each training should include a training agenda. [Appendix 2](#) provides a sample agenda and suggestions about how to modify it for each training modality. Similarly, all training should have an introduction that includes an explanation of gender competency, as well as the purpose, format, and how to access the self-assessment tool and eLearning course. A sample presentation adapted from the one used in the demonstration trainings is included in [Appendix 3](#). If the trainings are conducted in person or blended, hard copies of the self-assessment tool should also be provided.

To access the online materials, each training participant should be provided with approximately 5 GB of network data. Each provider will also need a device to access the eLearning course, which can be a smartphone, tablet, or computer. It is recommended that participants use headphones when completing the course modules. While headphones are optional for virtual training, they are required for in-person and blended trainings since providers will be working in the same space. For in-person and blended trainings, it is also recommended that the team bring a backup modem in case there is a problem accessing the internet from the facility hosting the training. For the blended and virtual training, it is recommended that providers and the team have access to a free text messaging app such as WhatsApp. This application is commonly used globally and was familiar to all providers.



In terms of implementation team members, it is recommended that one person with expertise in gender competency and FP moderate the training, and that an IT specialist is also available to support providers. A “trainer of trainers” model may be used to develop future moderators from those who have completed a previous gender competency training. For example, in Ghana, this may include regional resource team members.

It is recommended that an incentive be provided to participants to complete the course. This may be monetary but can also be in the form of continuing professional development credits or other educational credits if used as part of the nursing or pre-service curriculum. Certificates can also serve as a form of provider incentive. Provision of data across training modalities could also be used as an incentive and would enable participants to access other online FP training materials after completion of the course.

Finally, for in-person and blended trainings, implementation teams should consider reimbursement of transportation costs. Alternatively, in-person and blended trainings could be conducted at healthcare or nearby facilities so that the implementation team travels to the site rather than providers traveling to a different location.

**Table 3. Summary of resource needs for FP provider gender competency by training modality**

	Item
Materials	<ul style="list-style-type: none"> <li>• Agenda</li> <li>• Introduction slide deck</li> <li>• 5 GB data bundle per providers</li> </ul>
Equipment	<ul style="list-style-type: none"> <li>• Smartphone, tablet, or computer for each provider</li> <li>• Headphones</li> <li>• Modem</li> <li>• WhatsApp text messaging app</li> </ul>
Team capacity	<ul style="list-style-type: none"> <li>• Moderator trained in gender competency</li> <li>• IT specialist</li> </ul>
Provider incentives	<ul style="list-style-type: none"> <li>• Monetary</li> <li>• Continuing professional development points</li> <li>• Certificates</li> </ul>
Transportation	<ul style="list-style-type: none"> <li>• Reimbursement of travel costs</li> </ul>

## Discussion

The findings from this case study provide valuable insights about how to design training to strengthen the gender competency of FP providers using the gender competency provider self-assessment tool and eLearning course. Feedback from providers further validates that the gender competency content is valuable to FP providers, effectively addresses complex gender-related issues, and is an area in which providers welcome additional and on-going training (Andrinopoulos et al., 2023b). Providers were particularly enthusiastic about the topics of engaging men and boys as partners and users and addressing GBV. To support providers in their efforts to address these issues with clients, increased coordination across health sectors and community outreach is needed. For addressing GBV, connections to people and organizations equipped to provide these services are also required. Thus, in addition to equipping

providers with knowledge and skills in these areas, it is important to address the context within which providers work and how they can be linked to resources in these areas.

While virtual training can provide the greatest benefit in terms of reach, cost, and convenience, it is ineffective for the subset of participants who do not access or complete the tool and eLearning course. Despite providing monetary incentives, technology support, and text message reminders, 35% of providers in the virtual training did not complete the eLearning course in the week between virtual meetings. This was not true for the blended training, wherein providers were also tasked with completing the majority of the course on their own asynchronously and thus faced similar challenges (e.g., poor network connection, competing work, and personal tasks). One reason for this difference could be the interpersonal connection with the implementation team developed through the first session of the blended training, which was an in-person meeting. During the session, all providers logged in and completed the first modules, allowing the team to mitigate any technology issues in real-time and acclimate the providers to the course format. This initial engagement may have made it more likely for them to continue the course on their own. This interpersonal connection with the team and other providers may also have increased the social pressure providers felt to complete the course before engaging with the group during the follow-up meeting.

Lower course completion rates during the virtual training may also be a result of the extensive geographic distribution of providers compared to the other trainings, with more rural settings represented and less stable access to the internet. Including providers from all regions in the virtual training may have increased participation of providers with lower digital literacy from rural settings with weaker internet access. Indeed, there was more contrast in provider perspectives within the virtual group, which had national representation compared to the other training modalities; some participants were strongly in favor of virtual training, while others expressed wanting face-to-face interaction. Better outcomes may be achieved if audience segmentation is considered such that the training modality is varied depending on the internet connectivity, provider preference, and digital literacy of providers.

Internet network connectivity is a structural barrier that makes asynchronous work in blended and virtual training modalities difficult. A total of 67% of modules completed asynchronously were completed during the providers' off-hours. Providers explained that their reason for doing so was because the internet network was stronger in the evening. In fact, some participants stayed at their work facility after work to access better internet than what was available in their own home. In the virtual training, some providers traveled to other communities to be able to access a better network to complete the course and join Zoom meetings. Thus, potential benefits of asynchronous learning, including convenience and eliminating the stress and cost of travel, are not uniformly realized in low internet network areas.

Peer-to-peer engagement was a highly valued component of the in-person and blended training, and an important part of the learning process for gender competency. For providers, this discussion with other providers facing similar issues validated the gender-related challenges they encounter in their work. Engaging with other providers helped them discuss local applications and solutions so that the information that was developed for a global audience was more specifically contextualized for Ghana. It was difficult to foster this same richness of discussion via Zoom meetings in the virtual training sessions. However, the potential for better peer engagement exists for virtual trainings as well if different approaches to engagement are used (for example, individualized coaching via text and phone calls,

moderated group chats about each module, creating a buddy system that pairs participants via text). To maximize the impact of gender competency training and other global eLearning activities in the future, further innovations to foster engagement among participants in virtual learning platforms are needed.

Key findings:

- Providers found the gender competency training content relevant to their work and recommend training additional FP providers.
- Virtual training is less costly and can potentially increase access to providers not typically selected for trainings, but it leads to lower course completion compared to in-person and blended training.
- Internet network connectivity is a persistent challenge. The benefits of virtual training (convenience, less travel) are not uniformly realized in low internet network areas and could lead to the exclusion of providers in these areas.
- Digital literacy and preference for face-to-face interaction may prevent some providers from fully engaging in virtual training, leading to a selection bias in training reach if alternative formats are not offered.
- Peer-to-peer engagement is an important part of the learning process for gender competency. Virtual training should include additional mechanisms to connect training participants to the facilitation team and other participants.

## Recommendations

The positive findings in this exploratory case study suggest that further research on the effectiveness of training using the self-assessment tool and eLearning course to increase FP providers' gender competency is warranted. Additional research is also warranted to better understand the sustainability of different training modalities and to conduct a cost analysis of training using these resources. Using the tool and eLearning course together, with structured support provided to training teams, is recommended, rather than simply making providers aware of their ability to access resources online and encouraging them to do so. This will enrich the learning experienced by providers and their ability to develop concrete next steps to address the complex gender issues faced in their day-to-day work. Rather than a “one size fits all approach,” the training modality (in-person, blended, virtual) should be tailored to the audience based on the resources available as well as internet connectivity, provider preference, and digital literacy. These factors are summarized in Table 4, which can be used by teams to decide which training modality is most appropriate for their audience.

The most critical factor to consider is internet connectivity, which is required to download the self-assessment tool and to stream the eLearning course. Teams should first determine if providers will have access to high or low internet connectivity. For those with low connectivity, only the in-person and blended modalities are recommended. Next, teams should consider the personal attributes of their providers, including their level of digital literacy and whether their preference is for face-to-face or virtual learning. For those with high internet connectivity, all three training modalities might be considered. Within this group, virtual should be prioritized for providers with both high digital literacy and preference for online learning. If providers have lower digital literacy or preference for in-person learning, then in-person and blended trainings might be considered. Balancing these factors against cost is also important to consider.

**Table 4. Factors to consider when selecting a training modality**

	High internet network connectivity	Low internet network connectivity
Preference for online, high digital literacy	Virtual	Blended
Preference for online, low digital literacy	Blended	Blended In-person
Preference for in-person, high digital literacy	Virtual Blended In-person	Blended In-person
Preference for in-person, low digital literacy	In-person Blended	In-person

Structured trainings should cultivate provider peer-to-peer engagement based on the material in the gender competency tool and eLearning course. As a starting point, questions from the self-assessment tool discussion guide can be used to facilitate the discussion. This engagement will help providers contextualize the global materials so that concrete next steps in their local environments are identified.

For example, this might include a referral list of GBV service providers in their area and information about local laws and policies related to FP services. Opportunities to enhance engagement virtually should also be included in trainings. For in-person trainings, providers could set up a group chat via WhatsApp or similar, so that providers can continue to engage after the training as they apply the gender-related skills in their work. For the blended and virtual training, remote coaching from a moderator and group chats should be included during the asynchronous work to enhance engagement and promote accountability in completing the course.

Each training modality presented different strengths and challenges. Suggestions for future trainings to address these include:

1. For in-person and blended training, when possible, send the facilitation team to the healthcare facilities of providers rather than requiring travel to a centralized meeting place.
2. Provide the option for providers to self-select into an in-person, blended, or virtual training so that the modality is most appropriate to their needs and abilities.
3. Provide at least 5 GB of data so that participants can complete the eLearning course and participate in virtual meetings.
4. Include support from an IT specialist and make it easy for participants to contact them, for example via text messaging.
5. Arrange for incentives for tool and eLearning course completion in the form of monetary incentives, continuing professional development credit, and certificates.
6. Include leadership in training so that a “trainer of trainers” model can be employed in future training. In Ghana, this should include members of the regional response teams.
7. Provide reminders to participants during asynchronous work to complete the tool and eLearning course and contact the team with any questions or issues.
8. Provide sufficient time for asynchronous work, considering network connectivity issues, and that some providers will need to stay at work or travel to another community to get online.
9. Maintain connection to participants in blended and virtual training through group text messaging and virtual coaching. Use the group reflection questions from the self-assessment tool discussion guide to develop prompts for group chats.

These recommendations should be weighed against available funds and implementation team capacity for the training. However, many recommendations can be implemented at low cost with advance planning and ongoing structured support from leadership. The gender competency self-assessment tool and eLearning course are resources developed with global input, and both have received positive reviews by providers in Ghana. Wider application of these resources through in-person, blended, and virtual trainings can help providers strengthen their gender competency and improve FP services.

## Conclusion

Gender competency is important for FP providers and can be strengthened using an existing provider self-assessment tool and eLearning course. These resources can be applied in trainings that are in-person, blended, or virtual. Selection of the training modality should consider the strength of internet network connectivity, learning preference, and digital literacy of providers, as well as the resources available to conduct trainings.

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## Appendix 1. Provider Feedback on Module Content

**Appendix Table 1.1. Participants response to the question “Did you like or dislike the content of this module?”**

	Gender sensitive communication	Promoting individual agency	Supporting legal rights and status related to family planning	Engaging men and boys as partners and users	Facilitating positive couples’ communication and cooperative decision making	Addressing gender-based violence
Strongly like	26	21	22	20	18	20
Like	3	2	2	2	4	2
Dislike	0	0	0	0	0	0
Strongly dislike	0	0	0	0	0	0
No differences between female and male respondents reporting strongly like/like vs. dislike/strongly dislike						

**Appendix Table 1.2. Participants response to the question “To what extent did you agree or disagree with the content and answers presented in this module?”**

	Gender sensitive communication	Promoting individual agency	Supporting legal rights and status related to family planning	Engaging men and boys as partners and users	Facilitating positive couples’ communication and cooperative decision making	Addressing gender-based violence
Strongly agree	23	20	20	21	19	18
Agree	6	3	4	1	3	4
Disagree	0	0	0	0	0	0
Strongly disagree	0	0	0	0	0	0
No differences between female and male respondents reporting strongly agree/agree vs. disagree/strongly disagree						

**Appendix Table 1.3. Participants response to the question “The content in this module is relevant to the needs of my clients.”**

	Gender sensitive communication	Promoting individual agency	Supporting legal rights and status related to family planning	Engaging men and boys as partners and users	Facilitating positive couples’ communication and cooperative decision making	Addressing gender-based violence
Strongly agree	26	23	23	21	21	20
Agree	3	0	1	1	1	2
Disagree	0	0	0	0	0	0

Strongly disagree	0	0	0	0	0	0
No differences between female and male respondents reporting strongly agree/agree vs. disagree/strongly disagree						

**Appendix Table 1.4. Participants response to the question “The content in this module is relevant to the challenges I encounter when providing services.”**

	Gender sensitive communication	Promoting individual agency	Supporting legal rights and status related to family planning	Engaging men and boys as partners and users	Facilitating positive couples’ communication and cooperative decision making	Addressing gender-based violence
Strongly agree	23	20	21	17	18	17
Agree	5	2	3	5	4	5
Disagree	1	0	0	0	0	0
Strongly disagree	0	1	0	0	0	0
No differences between female and male respondents reporting strongly agree/agree vs. disagree/strongly disagree						

**Appendix Table 1.5. Participants response to the question “The content in this module is relevant to the skills needed by family planning providers.”**

	Gender sensitive communication	Promoting individual agency	Supporting legal rights and status related to family planning	Engaging men and boys as partners and users	Facilitating positive couples’ communication and cooperative decision making	Addressing gender-based violence
Strongly agree	28	23	22	22	21	21
Agree	7	0	1		1	1
Disagree	0	0	1	0	0	0
Strongly disagree	0	0	0	0	0	0
No differences between female and male respondents reporting strongly agree/agree vs. disagree/strongly disagree						

**Appendix Table 1.6. Participants response to the question “I expect to use the information from this module again.”**

	Gender sensitive communication	Promoting individual agency	Supporting legal rights and status related to family planning	Engaging men and boys as partners and users	Facilitating positive couples’ communication and cooperative decision making	Addressing gender-based violence
Strongly agree	28	23	23	21	21	20
Agree	1		1	1	1	2



Disagree	0	0	0	0	0	0
Strongly disagree	0	0	0	0	0	0
No differences between female and male respondents reporting strongly agree/agree vs. disagree/strongly disagree						

**Appendix Table 1.7. Participants response to the question “Providers I know would be interested in completing this module.”**

	Gender sensitive communication	Promoting individual agency	Supporting legal rights and status related to family planning	Engaging men and boys as partners and users	Facilitating positive couples’ communication and cooperative decision making	Addressing gender-based violence
Strongly agree	26	23	21	19	19	18
Agree	3		3	3	3	4
Disagree	0	0	0	0	0	0
Strongly disagree	0	0	0	0	0	0
No differences between female and male respondents reporting strongly agree/agree vs. disagree/strongly disagree						

**Appendix Table 1.8. I am interested in further, more specialized training about the information in this module.”**

	Gender sensitive communication	Promoting individual agency	Supporting legal rights and status related to family planning	Engaging men and boys as partners and users	Facilitating positive couples’ communication and cooperative decision making	Addressing gender-based violence
Strongly agree	27	21	22	22	20	19
Agree	2	2	2	0	2	2
Disagree	0	0	0	0	0	1
Strongly disagree	0	0	0	0	0	0
No differences between female and male respondents reporting strongly agree/agree vs. disagree/strongly disagree						

## Appendix 2. Sample Training Agendas

### Gender Competency Training for Family Planning Providers

Every day, family planning providers are faced with gender-related issues that influence their clients' family planning decisions. These challenges can take many forms, from inequities in decision making power between men and women, to limited skills in couples' communication, lack of male engagement, and experiences of gender-based violence. Providers' own beliefs and attitudes about appropriate gender roles and behavior for women, men, girls, and boys, can also influence how they provide services. By gaining skills in gender competency, providers can better identify gender-related issues faced by their clients and help them navigate these issues to reach their family planning goals.

During this interactive workshop, providers will learn about the knowledge, attitudes, and skills that are important for providing gender competent family planning services. They will:

1. Complete a self-assessment tool to measure their gender competency.
2. Complete an eLearning course designed to strengthen their knowledge, attitudes, and skills in gender competency.

Date: [ ]

Time: [ ]

Location: [ ]

Sample in-person training agenda

Time	Session	Activity
8:30-9:00 AM	Registration	-Providers sign-in and obtain device preloaded with data or given data for their own device, provided headset
9:00-9:15 AM	Welcome	-Presentation
9:15-9:30 AM	Introduction	-Presentation
9:30 -11:00 AM	Self-assessment tool	-Providers individually complete and score the self-assessment tool
11:00-11:15 AM	<b>Break</b>	
11:15-12:30	eLearning course modules 0,1 and 2	-Providers guided on how to login to the eLearning course and do so -Providers individually complete eLearning course modules
12:30-1:15 PM	<b>Lunch</b>	
1:15-1:45 PM	Group discussion modules 1,2	-Moderated discussion using questions from self-assessment discussion guide

1:45-2:45 PM	eLearning course modules 3, 4	-Providers individually complete eLearning course modules
2:45- 3:15 PM	Group discussion modules 3,4	-Moderated discussion using question from self-assessment discussion guide
3:15-3:30 PM	Break	
3:30-4:30 PM	eLearning course modules 5,6	-Providers individually complete eLearning course modules
4:30-5:00 PM	Group discussion modules 5,6	-Moderated discussion using question from self-assessment discussion guide
5:00-5:30	Certificate distribution Closing and wrap-up	

#### Sample blended training agenda

Time	Session	Activity
<b>Day 1</b>		
8:30-9:00 AM	Registration	-Providers sign-in and obtain device preloaded with data or given data for their own device, provided headset
9:00-9:15 AM	Welcome	-Presentation
9:15-9:30 AM	Introduction	-Presentation
9:30 -11:00 AM	Self-assessment tool	-Providers individually complete and score the self-assessment tool
11:00-11:15 AM	<b>Break</b>	
11:15-12:30	eLearning course modules 0,1 and 2	-Providers guided on how to login to the eLearning course and do so -Providers individually complete eLearning course modules
12:30-1:30 PM	<b>Lunch</b>	
1:30-2:00 PM	Group discussion modules 1,2	-Moderated discussion using question from self-assessment discussion guide
2:00-2:30	Action plan for asynchronous learning and wrap-up	-Providers discuss when and where they plan to complete remaining modules

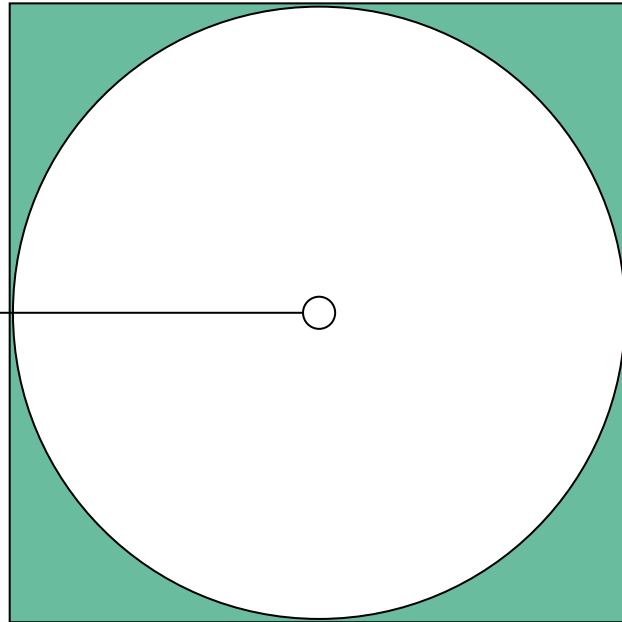
		-Providers connected via WhatsApp text messaging and text message sent
<p><b>Asynchronous learning week</b> providers access the eLearning course available at this <a href="#">link</a>, complete modules 2-6 of the eLearning course and the knowledge assessment [in settings with lower internet access, may need more than one week between meetings]</p> <p>-Implementation team sends group chats including: link to eLearning course, reminders to complete the course, questions about modules from the self-assessment tool discussion guide</p>		
<b>Day 2</b> [in-person agenda provided, can be modified for a virtual meeting]		
8:30-8:45 AM	Registration	
8:45-9:00 AM	Welcome and introduction to Day 2	
9:00-10:00 AM	Group discussion about all content and plans for application	-Moderated discussion using question from self-assessment discussion guide
10:00-10:30 AM	Certificate presentation and closing	

### Sample virtual training agenda

Time	Session	Activity
<b>Virtual meeting 1</b>		
9:00-9:15 AM	Welcome	Presentation
9:15-10:00 AM	Introduction -Explain components of the training, how to login	Presentation
<p><b>Asynchronous learning week</b> providers access the eLearning course available at this <a href="#">link</a>, complete modules 0-6 of the eLearning course and the knowledge assessment [in settings with lower internet access, may need more than one week between meetings]</p> <p>-Implementation team sends group chats including: link to eLearning course, reminders to complete the course, questions about modules from the self-assessment tool discussion guide</p>		
<b>Virtual meeting 2</b>		
Hourlong	Group discussion about all content and plans for application	-Moderated discussion using question from self-assessment discussion guide -If larger group, breakout rooms should be used to maintain groups of 10 or less

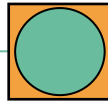
## **Appendix 3. Sample Training Introduction Presentation**

A sample PowerPoint presentation of the Gender Competency Training is presented in full beginning on the next page.



# Gender Competency Training

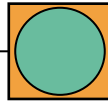




# Meeting Goal and Objectives

The overall goal of the activity is to strengthen provider's knowledge, attitudes, and skills related to gender competency. During today's meeting you will learn how to:

1. Complete a self-assessment tool to measure gender competency
2. Complete an eLearning course on gender competency
3. Provide feedback on the tool and course



# Gender Competency

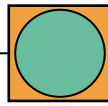
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The knowledge, attitudes, and skills that can help providers reduce gender-related barriers for their clients.

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With increased gender competency, providers can be more responsive to the diverse needs of their clients and deliver high-quality FP services.



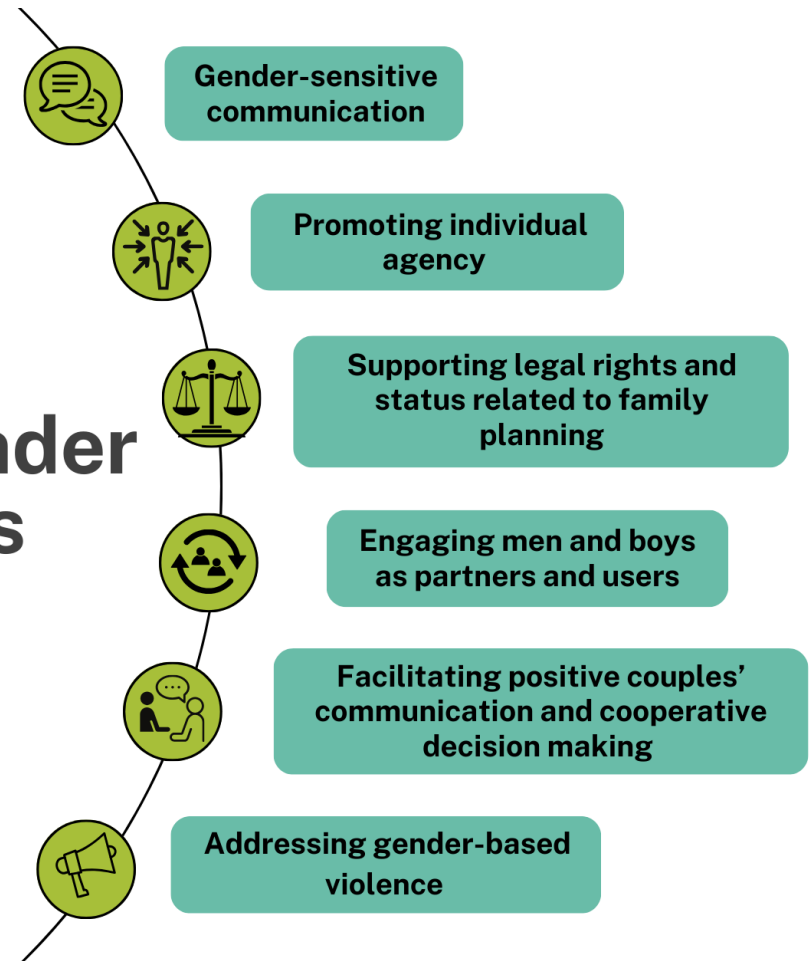


# The Gender Competency Framework

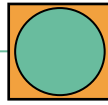
Each dimension includes:

- Knowledge
- Attitudes
- Skills

## Key Gender Domains

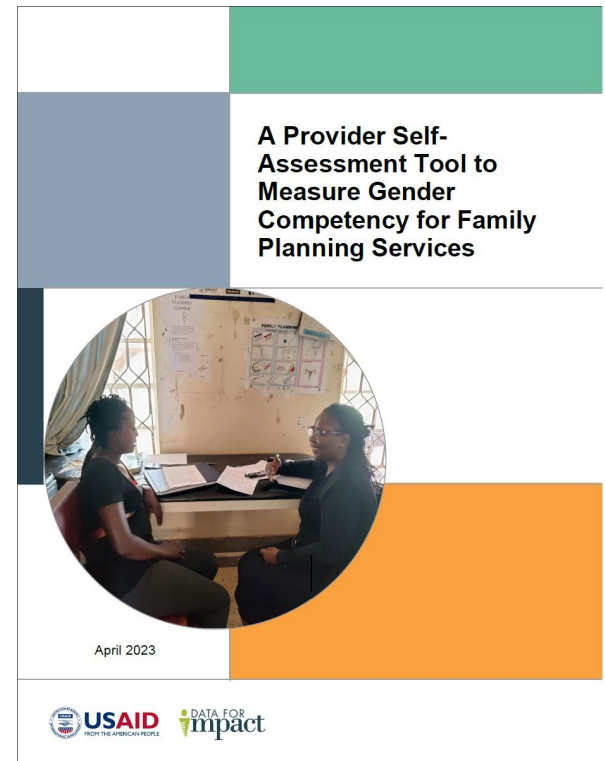


Developed by HRH2030



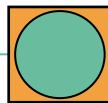
# Provider Self-Assessment Tool

- By completing the self-assessment tool, providers measure whether they have high, medium, or low gender competency
- Each module contains:
  - Statements and responses
  - Answer key
  - Discussion guide
- Each module takes



Available at:

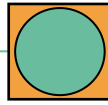
<https://www.data4impactproject.org/publications/gender-competency-tool-guidance/>



# Self-Assessment Tool Properties

- Six modules, 71 items in total
- Statements represent knowledge, attitudes, and skills in the domain
- Providers indicate if they “Strongly Agree, Agree, Disagree, or Strongly Disagree” with the statement
- About 10-15 minutes to complete each module

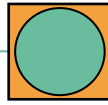
Gender Competency Module	Number of statements
A. Gender-sensitive communication	13
B. Promoting individual agency	15
C. Supporting legal rights and status related to family planning	10
D. Engaging men and boys as partners and users	13
E. Facilitating couples' positive communication and cooperative decision-making	7
F. Addressing gender-based violence	13
<b>Total</b>	<b>71</b>



# Gender Competency eLearning Course

- The course includes seven modules (introduction, and one module for each domain)
- Modules include video content and interactive knowledge checks
- It takes about 30 minutes to complete a module
- You can leave the course and resume again later
- Upon successful completion of a final assessment, you can download a certificate of completion

eLearning course developed by Human Resources for Health 2030  
<https://app.cloud.scorm.com/sc/InvitationConfirmEmail?publicInvitationId=2eba2575-5471-4dc6-b18b-f4ac25db9c1e>



# eLearning Course - Login

Please enter your info and we will move you right along.

Your correct email will ensure you receive proper credit for your training.

Email

First Name

Last Name

\* Your email address is your sole identification in SCORM Cloud. Please take a moment to make sure the one provided is correct. Thanks!

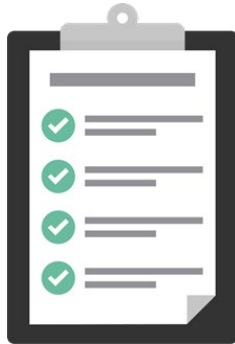
Ok. Now take me to my training



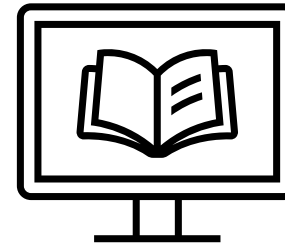
# Homework for the Week

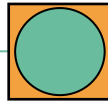
- Plan for about 4.0 hours of work this week

Step 1: Self-assessment tool



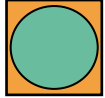
Step 2: eLearning course





# Technology Support

- If you encounter technical difficulties during the week, please contact [ ] at [phone] or [email]
- Please send a test message now

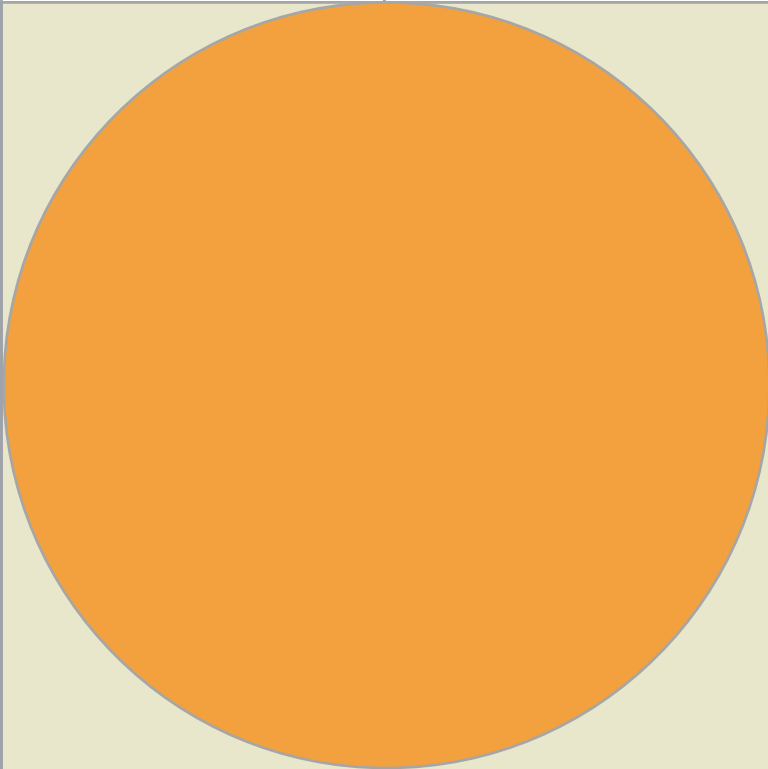


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