SHOPS PLUS

Assessment of Gender and Supportive Supervision in Nigeria

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Summary

Research shows that gender has a significant impact on workplace experiences and interactions in health care settings. However, efforts to address gender barriers for health care providers are limited. As part of its family planning program in Nigeria, SHOPS Plus implemented a gender-integrated supportive supervision pilot based on a conceptual framework known as *gender-transformative supportive supervision*. The project conducted an assessment to understand how the pilot was implemented, how training and discussions related to gender were received by supervisors and providers, and how these supervision sessions influenced provider outcomes related to staff retention and the quality of care. This brief presents the findings, implications for other health care settings, and recommendations for addressing gender barriers in the workplace with particular consideration for private sector contexts.

Keywords: family planning, gender, Nigeria, provider quality

Cover photo: KC Nwakalor

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Glossary of terms

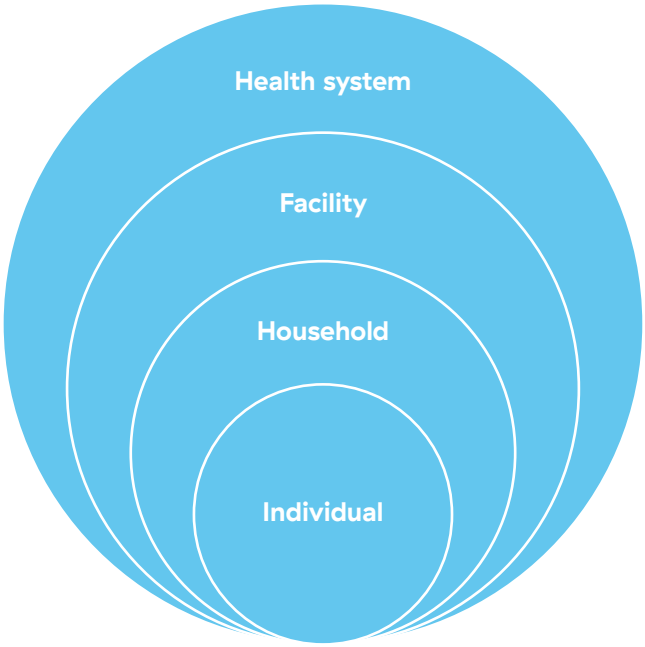
Gender-transformative	Approaches that examine and seek to change gender norms, as well as related attitudes and behaviors.
Gender discrimination	The denial of resources, rights, or privileges to a person or set of people based on gender.
Gender-sensitive coaching	A proactive approach that seeks to eliminate gender bias from communications between a coach and provider and identifies any unexamined gender-related barriers to performance.
Gendered power dynamics	Power is organized hierarchically in societies based on many factors including sexuality, race, and gender. The way power is organized in a society influences interactions between people. Gendered power dynamics focuses on the role gender plays in the organization of power in a society. For example, if men are assumed to be better suited for leadership, this might make women feel less comfortable or less empowered to speak up in a work environment. Gendered power dynamics influence professional relationships and greatly influence how power is negotiated within a family or romantic relationship.
Gender stereotypes	Oversimplified or unfair generalizations about people based on their perceived gender identity. Gendered stereotypes can affect the lives, jobs, and well-being of both women and men. For example, in many societies, women are perceived as being natural caregivers and are thus assumed to be better fit than men for caring jobs, like nursing or midwifery. This stereotype, as with all gender-based stereotypes, is based on specific cultural, economic, and social conceptions of femininity and masculinity.
Gender bias	Conscious or unconscious preference or prejudice toward one gender over the other. For example, an employer might choose to promote a male employee over a female employee based on their internal gender biases.
Gender norms	Social norms that influence behavior, attitudes, and expectations based on gender.
Occupational segregation	The grouping of sets of people in occupations or hierarchy levels based on a demographic characteristic, such as gender. Horizontal segregation is the grouping of people across occupations, such as men tending to be in leadership positions across occupations, and vertical segregation is the grouping of people within an occupation, such as women tending to be the majority of nurses.
Workplace gender issues and gender barriers	Blanket terms to describe interactions and dynamics that are influenced by gender biases and stereotypes and may result in gender discrimination and gender-related barriers to success.

Assessment of Gender and Supportive Supervision in Nigeria

Supportive supervision is a key human resource management function that involves interactions between supervisors and providers with the goal of improving health care provider performance. Research shows that gender—the expectations, roles, and power dynamics that society assigns to being male or female—has a significant impact on workplace experiences and interactions, in both public and private sector settings (Hastings 2017). Health care providers may face multiple barriers in the workplace related to their gender (Figure 1), several of which could be addressed in part by their supervisors through supportive supervision. Gender-transformative approaches actively seek to shift gender norms, attitudes, and behaviors to achieve desired results. According to the World Health Organization, "gender-transformative policies are needed to address inequities and eliminate gender-based discrimination in earnings, remove barriers to access to full-time employment, and support access to professional development and leadership roles" (Boniol et al. 2019). Despite the recognition of the importance of gender, little has been done globally to address gender-related barriers faced by providers in the context of supportive supervision.

Photo: KC Nwakalor

Figure 1. Layers of gender barriers in the workplace



Health system
National policies, pre–service training, and task shifting affect which professions men and women choose, how well they are paid, and how safe they are.

Facility
Facility policies and protocols on promotions, safety, and family leave affect providers' ability to coordinate household and work, advance their careers, and access professional development.

Household
Decisions about household responsibilities, time away from home, and childbearing affect career trajectory.

Individual
Individual biases affect expectations, attitudes, and behaviors of providers and their supervisors.

In Nigeria, the USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project developed and implemented a pilot program that used the gender-transformative supportive supervision (GTSS) conceptual framework as a basis for training supervisors who supported public and private family planning providers. The hypothesis of the framework is that GTSS can lead to improved provider job satisfaction and improved communication with supervisors. The former is linked to increased retention and the latter to improved feedback and performance. SHOPS Plus partner Iris Group developed the framework (Hastings 2017) for the USAID-funded Leadership, Management and Governance for Health project.

The program in Nigeria marks the first time, to our knowledge, that the GTSS conceptual framework was used to design and implement an intervention in the global health field. SHOPS Plus conducted an assessment to understand the implementation of this pilot, how it was received by providers and supervisors, and whether their experience suggests movement toward provider outcomes as outlined in the program's GTSS theory of change.

Context

Supportive supervision

Supportive supervision in health care is an approach to human resources management that emphasizes joint problem solving, communication, and positive feedback loops between supervisors and health care providers. Typical supportive supervision functions include supporting positive relationships, monitoring performance, addressing capacity gaps, two-way communication, and solving problems together. This management approach posits that poor supervisory methods contribute to negative interactions between supervisors and health care providers, creating a punitive environment. Such an environment can be demotivating for the provider and may block the flow of critical information between supervisors and supervisees, contributing to staffing challenges and lapses in quality of care.

For at least two decades, global health programs have integrated supportive supervision into their human resources management interventions to improve the quality of care and promote health worker retention in low-resource settings. These interventions typically target supervisory staff with training and tools, such as checklists on standards of care that are monitored during site visits. Research has shown that assistance with essential tasks, emotional and social support, and positive interpersonal interactions are critical to effective supportive supervision. However, some supervision interventions in low-resource settings may rely on off-site supervisors and focus more on checklist administration than supervisor-supervisee relationship development (Avortri, Nabukalu, and Nabyonga-Orem 2019; Madede, Sidat, and McAuliffe 2017).

Gender in the workplace

Gender inequalities are persistent in health care settings. For example, women are 70 percent of the health workforce globally, yet they hold only 25 percent of senior roles (Boniol et al. 2019). In the private sector, women are more likely than men to be in lower-paid jobs (such as personal care workers), which also tend to offer less job security and favor part-time employment (Boniol et al. 2019). At the same time, for highly paid occupations (such as physicians) where public sector wage ceilings often exist, men are more frequently employed in the private sector than are women (Boniol et al. 2019). A World Health Organization gender and equity analysis of the health workforce (WHO 2019) found a number of systemic gender inequalities (text box).

Systemic gender inequality in the workplace

Occupational segregation: Women and men in the health workforce tend to be clustered in different roles. Women face more barriers in becoming and serving as physicians, and men face barriers in becoming and serving as nurses. Women tend to be in lower-status and lower-paid jobs in the public and private sectors.

Leadership gaps: The predominance of men in leadership in a woman-dominated field reflects bias, power imbalances, and stereotypes. The gap is worse for women in less privileged racial and ethnic groups.

Discrimination and safety: Women experience job-related discrimination and sexual harassment. They may face more issues with safety in conflict-ridden areas.

Pay differentials: On average, female health workers are paid 28 percent less than male health workers. Much of the pay gap reflects differences in hours worked and provider type, two factors which may be due to gender imbalances. However, 11 percent of this pay gap is unexplained.

Source: WHO 2019

Gender in supportive supervision

Traditionally, human resources management interventions, including supportive supervision, have generally been gender-blind—implemented without attention to how gender norms and power dynamics might affect experiences in the workplace or the relationship between supervisors and supervisees.[1] In 2015, Iris Group developed a conceptual framework that explored the integration of gender into supportive supervision and potential outcomes from its implementation. A review of the literature and key informant interviews served as a basis for the framework, which focused on the family planning and HIV health workforce. The framework proposes a set of characteristic elements (Table 1) and ways health facility leadership could move away from gender-blind supportive supervision interventions (i.e., those implemented without consideration of gender norms and dynamics) toward those that promote an awareness of gender and power differences and seek to change them. Ideally, this would improve provider performance while advancing human rights and gender equality among health workers.

[1] Known exceptions are USAID's Maternal and Child Survival Program, which trained 30 facilitators and 1,000 health care providers in Nigeria to address gender inequality, including workplace inequality (MCSP n.d.). Jhpiego recently released a training toolkit on gender-transformative leadership for health workers to develop their understanding of and ability to address gender issues in the workplace (Jhpiego 2020). The toolkit includes training modules for effective mentoring and feedback.

Table 1. Illustrative considerations comparing gender-blind and gender-transformative supportive supervision

Gender-blind	Gender-transformative
Examines the impact of human resource policies and protocols on providers	Examines the differential impact that policies and protocols related to pay, sexual harassment, and family leave have on providers
Emphasizes positive feedback loops	Emphasizes examination of supervisor's biases to ensure these feedback loops are gender-equitable
Promotes joint problem solving	Promotes questioning of gender-based assumptions (i.e., men are smarter, women care more) to improve performance and help providers reach their goals

Gender in the SHOPS Plus program in Nigeria

The goal of the SHOPS Plus family planning program in Nigeria was to improve access to voluntary family planning services in four states: Akwa Ibom, the Federal Capital Territory, Oyo, and Plateau. From 2017 to 2020, SHOPS Plus implemented a program to increase access to contraceptives by improving the ability of public and private providers to deliver quality family planning services and enhancing the quality of counseling and service delivery. SHOPS Plus staff developed a training approach that enriched supportive supervision and strengthened systems to promote quality improvement and data management for decision making. The program trained 661 public sector providers (75 percent were women) and 270 private sector providers (60 percent were women) on improving the quality of family planning service provision. Providers trained by SHOPS Plus came from different educational backgrounds; while most (59 percent) were community health extension workers, others (35 percent) were nurses or midwives, and a few (6 percent) were physicians.

Across the four states, the project also trained supervisors of these providers—35 local government area (LGA) family planning and reproductive health coordinators (all were women and state employees) and 58 coaches (49 women and 9 men engaged by SHOPS Plus)—on how to provide post-training follow-up and supportive supervision for the SHOPS Plus-trained providers. The LGA family planning coordinators were nurses or midwives who are responsible for overseeing family planning service delivery among public and private providers in their LGA. Coaches trained by SHOPS Plus were selected from the group of family planning service provision trainers and are experienced nurses, midwives, and physicians from the community. (Some

were retired from medical practice.) The program intended that coaches would provide guidance and support to the LGA family planning coordinators during supervisory visits to providers.

In 2018, SHOPS Plus conducted a gender assessment in Nigeria to shape the design of its initiative and build capacity among family planning providers. The assessment revealed substantial barriers created by gender inequality in provider-client interactions. In response, project staff incorporated gender modules into the family planning service delivery training for providers to address gender issues related to the client (Table 2, gender in service delivery section). The training helped providers understand their own potential gender biases toward their clients, raised awareness of gender-related barriers to accessing family planning, and promoted constructive male engagement in family planning.

The assessment also revealed widespread issues related to provider gender in health facilities (Table 2, gender in the workplace section), including safety concerns for female health workers, bias about men being more competent than female providers, and occupational segregation of men as community health workers and women as nurses. The team also learned that supervisory checklists focused on clinical skills, without any prompts to discuss gender-related barriers in the workplace. In this context, the project team proposed the creation of an implementation model for GTSS, including a training module and incorporation of a tool to facilitate discussions on gender in the workplace in supportive supervision visits. Providers, LGA family planning coordinators, and coaches were assumed to have limited to no prior experience with supportive supervision and no prior exposure to discussing or addressing gender barriers (provider-level) in the workplace. These assumptions were partially confirmed by findings in this assessment.

Table 2. Comparison of gender in the workplace and in service delivery

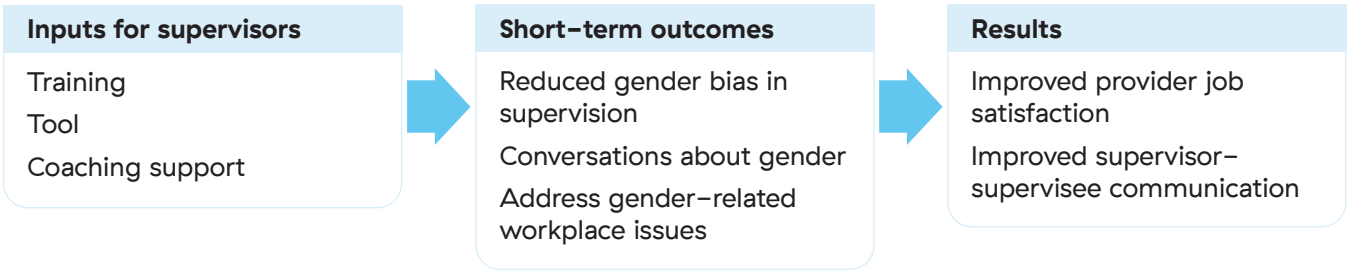
	Relationship	Common examples of gender inequality in family planning service delivery
Gender in the workplace—focus of GTSS	Provider–supervisor	• A supervisor denies a provider a job opportunity because of assumptions based on the provider's gender • A supervisor judges a provider's performance differently because of the provider's gender • A supervisor sexually harasses a provider or refuses to pursue accusations of sexual harassment
	Provider–facility or provider–health system	• Lack of policies that support paid family leave • Policies and practices that lead to unequal pay for equal work • Lack of safety mechanisms in areas where women providers are at risk for sexual or other violence
Gender in service delivery—NOT the focus of GTSS	Client–provider	• A provider requires permission from a client's partner to access family planning • A provider refuses long-acting contraception if a woman has not had a certain number of children • A provider denies access to family planning to an unmarried woman
	Client–facility or client–health system	• Lack of access to a range of family planning methods • Lack of coverage of family planning methods in public insurance • Lack of training and protocols for family planning providers in a range of family planning methods or in response and referral on gender-based violence

Implementing supportive supervision with a gender lens

To address the need for GTSS among providers trained by SHOPS Plus, Iris Group developed a one-day training module and counseling tool with input from Nigerian providers and coaches. The module was part of a comprehensive three-day training on coaching and supportive supervision skills for coaches and supervisors who were to oversee service delivery by the SHOPS Plus-trained providers. The module promoted gender-sensitive coaching, helped coaches and supervisors examine their own gender biases, and raised their awareness of common workplace gender issues. The training introduced the GTSS counseling tool (Annex) to help supervisors discuss these issues during supervision visits. The interactive training allowed participants to practice conversations with a partner. The tool included parameters and sample language for discussing gender in the workplace, as well as a series of questions for providers addressing gender discrimination, upward mobility, facility policies, sexual harassment, and travel and safety.

The GTSS theory of change (Figure 2) proposes that supervisors equipped with GTSS training, a GTSS tool, and support from a trained coach will (1) shift their beliefs and attitudes around gender in the workplace to reduce gender bias in supervisory interactions, (2) initiate constructive conversations about gender in the workplace with the health care providers they visit, and (3) work with providers to address gender-related issues that arise in these conversations. As postulated by the theory of change, reduced supervisory bias, constructive supervisor-supervisee conversations, and joint problem solving around gender barriers will lead to improved provider job satisfaction and communication with supervisors. Ultimately, improved satisfaction and communication are critical factors that support quality service delivery at the facility level.

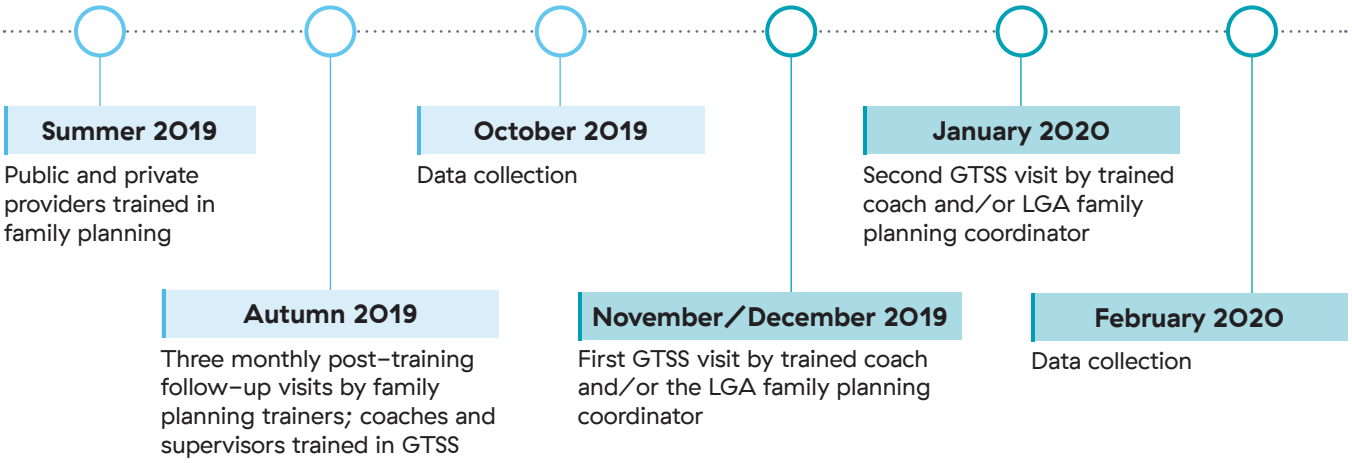
Figure 2. Gender-transformative supportive supervision theory of change



In September 2019, SHOPS Plus trained LGA family planning coordinators, coaches, and private facility managers in Akwa Ibom and Oyo. Each participant was provided with the GTSS tool to use in provider supportive supervision visits. While LGA family planning coordinators and coaches were trained in GTSS as part of a comprehensive training on supportive supervision, private facility managers only received training in GTSS.[2] All SHOPS Plus-trained providers received two GTSS visits from the coach or LGA family planning coordinator following the completion of their training and post-training follow-up visits (Figure 3).

[2] Private facility managers, as the direct supervisors of the SHOPS Plus–trained providers, were included in the GTSS training to introduce them to concepts around gender in the workplace with the expectation that they might supervise with increased gender awareness using the GTSS tool, regardless of whether or not they practiced all the other elements of supportive supervision.

Figure 3. Timeline of family planning training and GTSS in Oyo and Akwa Ibom



A GTSS visit includes skills observation and feedback, a gender discussion, admin reviews, an action plan, and meeting with a facility team.

The public sector's LGA family planning coordinators perform supportive supervision visits to facilities periodically. As the supervisors responsible for oversight of the family planning service delivery of trained providers in both the public and private sectors, and with sustainability in mind, the LGA family planning coordinators were trained to deliver GTSS visits, initially with support from the SHOPS Plus coaches.

As described above, the SHOPS Plus program in Nigeria trained family planning providers on issues related to client gender—to examine and confront their gender biases that might interfere with service provision, and to engage men constructively in service delivery. However, they were not trained in GTSS, and prior to the GTSS visits they were not sensitized to issues related to their own gender and how it affects them and their peers in their workplaces.

Assessment objectives and methods

Objectives

SHOPS Plus designed an assessment to understand how GTSS was implemented, how it was perceived, and whether there was movement toward the positive provider outcomes hypothesized in the theory of change. The purpose of this assessment was to examine SHOPS Plus's operationalization of the GTSS model in Akwa Ibom and Oyo states by pursuing the following objectives:

1. Examine whether supervisors', coaches', and private providers' experiences with and perspectives on GTSS suggest:
   a. Understanding of and receptiveness to discussing gender barriers in the workplace
   b. Movement toward the short-term, provider-level outcomes hypothesized by the GTSS theory of change increased job satisfaction and improved supervisor-provider communication
2. Assess whether accounts of supervisors' and coaches' implementation of GTSS visits aligned with the approach envisioned in the program's theory of change

Methods

This mixed-methods assessment used focus group discussions, in-depth interviews, and a structured, pre-post survey (conducted before and after the GTSS visits) to capture perspectives, observations, and experiences from providers who SHOPS Plus trained to implement the GTSS model, as well as the public and private providers who received GTSS visits as a part of their participation in SHOPS Plus's family planning training program. Table 3 provides the final sample composition for the assessment.

GTSS implementers

The assessment used focus group discussions to better understand GTSS implementation from the perspective of the training participants. SHOPS Plus held two focus group discussions with coaches, two with LGA family planning coordinators, and one with private facility managers responsible for delivering GTSS in SHOPS Plus-affiliated public and private health facilities. Moderators used semi-structured discussion prompts to explore a variety of concepts including implementers' understanding of gender and GTSS, their knowledge and observations of workplace-related gender issues, how they delivered the GTSS module to providers, and what they perceived were the impacts of the module on their own supervision practice and relationships with supervisees.

Public and private providers

The assessment used in-depth interviews to examine providers' experiences with GTSS and the perspectives and observations of workplace gender dynamics and issues. It also used a pre-post quantitative survey to measure the difference in perceived job satisfaction and gender perceptions before and after GTSS implementation. The pre-post survey was administered to all 100 providers (30 private; 70 public) who received GTSS visits between November 2019 and January 2020. Interview participants were randomly selected from these 100 providers, from 10 public and 19 private facilities, after the conclusion of their second GTSS visit.

Pre-GTSS data collection took place in October 2019. The post-GTSS survey and all in-depth interviews and focus group discussions were conducted in February 2020 after providers had received two GTSS visits from LGA family planning coordinators and coaches.

Table 3. Sample size composition

Informant	Trained by SHOPS Plus*	Participants	Selection method
Coaches (2 focus group discussions)	**Akwa Ibom** 15 (3 male, 12 female) **Oyo** 15 (3 male, 12 female)	**Akwa Ibom** 6 participants in 1 focus group discussion (3 male, 3 female) **Oyo** 5 participants in 1 focus group discussion (1 male, 4 female)	7 coaches from each state were randomly selected for recruitment into a state-specific focus group discussion.
LGA family planning coordinators (2 focus group discussions)	**Akwa Ibom** 6 (all female) **Oyo** 6 (all female)	**Akwa Ibom** 6 participants in 1 focus group discussion (all female) **Oyo** 6 participants in 1 focus group discussion (all female)	All LGA family planning coordinators were invited to participate in a state-specific focus group discussion session.
Private facility supervisors (1 focus group discussion)	**Akwa Ibom** 10 (all male) **Oyo** 10 (8 male, 2 female)	**Akwa Ibom** No focus group discussion (all declined to participate) **Oyo** 4 participants (all male)	7 private facility supervisors were randomly selected for recruitment into focus group discussions in each state.
Private providers (19 in-depth interviews and 30 pre-post survey participants)	**Akwa Ibom** 12 (3 male, 9 female) **Oyo** 21 (11 male, 10 female)	**Akwa Ibom** 9 in-depth interview participants (8 female, 1 male) 11 survey participants (9 female, 2 male) **Oyo** 10 in-depth interview participants (6 female, 4 male) 19 survey participants (9 female, 10 male)	A survey was administered to all providers who received GTSS after November 2019; random selection from survey sample for in-depth interviews. The sample size was determined considering available resources and guidance from the literature on appropriate sample sizes for qualitative research.
Public providers (10 in-depth interviews and 70 pre-post survey)	**Akwa Ibom** 65 (1 male, 64 female) **Oyo** 55 (5 male, 50 female)	**Akwa Ibom** 5 in-depth interview participants (5 female) 39 survey participants (38 female, 1 male) **Oyo** 5 in-depth interview participants (4 female, 1 male) 31 survey participants (26 female, 5 male)	

*While SHOPS Plus trained a total of 77 providers in Akwa Ibom state and 76 providers in Oyo state, only 50 from each state were included in our study, since the others had already received their first GTSS visit before we were able to administer our "pre-GTSS" survey.

Data analysis

Qualitative data analysis. SHOPS Plus researchers used NVivo 12 to analyze focus group discussion and in-depth interview transcripts using both deductive and inductive coding approaches. They used deductive approaches to generate an initial codebook based on research questions, focus group discussions, and in-depth interview guides. The team then adapted the codebook using an inductive approach based on emerging themes in the data. Two researchers conducted the NVivo coding. To ensure consistency, the team double-coded one transcript for each informant type and conducted periodic coding reviews to ensure ongoing agreement between team members. Once coding was complete, the team used NVivo's query functions to generate coding frequencies and intersections to identify the most common themes for each topic covered in the focus group discussions and in-depth interviews. Throughout this process, the team maintained analytical memos to describe and distill thematic patterns that were observed; these memos were consulted as key findings across topics and informants were synthesized.

Quantitative data analysis. Researchers used Stata 14 to tabulate survey results, and disaggregated the data by public and private providers. Pre- and post-GTSS responses were compared to assess differences, noting changes of more than 20 percent on the Likert scale. Due to the size and nature of the sample, significance testing was not possible. Any changes in values are illustrative and not definitive.

Photo: KC Nwakalor

Key findings, implications, and recommendations

Key findings, implications, and recommendations

Assessment findings are presented in three main groups that align with the research objectives: (1) gender perceptions and barriers in the workplace, (2) implementation of GTSS, and (3) provider outcomes of GTSS. For each objective, key findings are presented followed by a summary of lessons learned, implications, and recommendations.

Gender perceptions and barriers in the workplace

LGA family planning coordinators and private facility supervisors demonstrated a partial understanding of how gender issues can affect providers in the workplace; coaches had a better understanding. Overall, informants were comfortable discussing issues of gender in supervision sessions.

Coaches trained on GTSS expressed that concepts related to gender resonated with them. One coach explained how gender discrimination is everywhere despite the fact that no one talks about it. Another described the potential of GTSS:

"I will just say that GTSS is a new one with great potentials to break many barriers related to gender issues." — *Coach, male, Oyo*

Coaches appeared to comprehend concepts associated with how a provider's gender can be related to barriers they face in their workplaces. Some coaches expressed how the GTSS training deepened their understanding and challenged their own personal gender biases:

"We imbibe social norms growing up . . . [such as that] females are generally lazy so you give them little responsibility compared to men . . . and if a woman may want to aspire for a higher post maybe [she] will have to prove herself twice what you expect from a man."
— *Coach, male, Oyo*

" . . . I was able to learn that whether male or female, we need to treat them the same way, we don't need to discriminate, we don't need to even give preference to any gender . . . "
— *Coach, female, Oyo*

In focus group discussions, LGA family planning coordinators did not demonstrate the same understanding of how gender might affect providers and the relationship between providers and supervisors, with informants unable to provide examples of possible workplace gender discrimination. While a few coordinators trained on GTSS demonstrated some understanding, most seemed to conflate the concept of gender barriers that providers face with issues related to clients' gender and service delivery:

"... this gender something [sic] has really increased my knowledge of the role of men in family planning. They can also access family planning services; they can support their wives in whatever method she has chosen. Then men can work as agents of change in the community ..." — *LGA family planning coordinator, female, Oyo*

Coaches had prior experience training providers on issues related to client gender in the SHOPS Plus family planning training that they typically delivered. LGA family planning coordinators participated in the training as well, though as trainees, and therefore had been exposed to gender concepts (related to client gender), but not to the same extent as coaches who were the trainers.

Unlike coaches and supervisors, providers did not receive training in GTSS nor were they sensitized to gender workplace issues through training. Their first formal exposure to ideas of how gender could affect them in the workplace (as opposed to issues around client gender in family planning service delivery) would most likely have been during their GTSS sessions with the supervisors and coaches. During interviews, while some providers confused workplace gender issues with gender in service delivery issues (which, while important, are not the focus of GTSS), about half of interviewed providers demonstrated some understanding of how their gender could affect them in the workplace.[3]

"... I think gender bias ... can affect [the workplace] because maybe some male[s] ... they may feel that they are supposed to be on top, they are supposed to be leading, not the women to lead them."
— *Private facility provider, female, Akwa Ibom*

"... the fact that they address that gender ... has given me that knowledge of being able to see men and women as equal person[s] that can even work equally, that there won't be any discrimination ..."
— *Private facility provider, female, Oyo*

[3] While focus group discussion informant responses cannot be quantified, responses from the 29 in-depth interviews with providers are quantified as follows: few (1—6), some (7—13), half (14—16), many (17—23), and most (24—28).

Eleven providers recalled discussing gender in the workplace during their GTSS sessions, but were unable to provide details of what they discussed. Of these providers, all but one indicated that they felt comfortable discussing it.

"Because she is a female, we discussed at length. There are some issues you cannot comfortably discuss with a man." — *Private facility provider, female, Akwa Ibom*

Though this provider appears to have felt comfortable because the supervisor was female, informants also included male providers who felt at ease. The comfort of these providers in discussing issues that were likely unfamiliar and not generally discussed in the workplace (or even outside of the workplace) was a key finding. Another provider explained:

"I felt comfortable [discussing issues related to gender] because I know gender issues are the things that should be brought to minimum in the society." — *Private facility provider, female, Akwa Ibom*

Bringing up issues of gender in the workplace did not cause (to our knowledge) negative side effects such as providers using the opportunity to complain (in a discriminatory way) about colleagues.

Coaches and supervisors also generally described feeling comfortable having discussions related to gender barriers in the workplace with their supervisees, in part because they are of the same gender.

" . . . okay maybe because majority of our providers in our local government especially are females so there are no bad feelings about it. They feel it's something normal; questions asked—they answer freely." — *LGA family planning coordinator, female, Akwa Ibom*

A male coach explained that despite the sensitivity of discussing issues with female providers, he was able to communicate as needed:

"It was quite sensitive, especially for me as a man; you know most of the nurses in our environment are women, so having those conversations was quite sensitive . . . but ultimately, we all realize that we are professionals also and we are communicating on a professional level . . . " — *Coach, male, Akwa Ibom*

Lessons learned

Gender and related barriers in the workplace—gender dynamics between supervisors and providers, and provider-level gender discrimination in the workplace—can be difficult concepts to comprehend. Understanding these concepts may be facilitated by prior exposure to gender concepts, since coaches demonstrated a clearer understanding than LGA family planning coordinators or private supervisors, whose prior exposure was more limited.

In terms of their understanding, providers tended to reference and relate to client-level gender dynamics issues more so than provider-level gender barriers in the workplace, as did LGA family planning coordinators, likely due to their prior exposure to the former. Providers and supervisors described generally feeling comfortable discussing issues related to gender in the workplace, especially when providers and supervisors were of the same gender. The fact that supervisors and coaches expressed that discussions on provider gender were important to address, together with providers' openness to discussing gender-related issues (whether related to the client or themselves) suggests that the issues outlined in the GTSS tool that were raised in GTSS sessions were well received by informants.

Implications and recommendations

With sufficient training and support, integrating gender into supportive supervision structures can raise awareness and facilitate initial conversations about workplace gender issues between supervisors and providers. Increased exposure over time to gender concepts can improve comprehension and application of these topics in a supervisory context. More research is needed to test GTSS in other contexts, particularly where there is less gender concurrence between providers and supervisors or where there has not been prior exposure to gender concepts. In targeting providers who already received gender training, GTSS projects can build on an understanding of gender dynamics to advance conversations about gender in the workplace, which include broader issues such as institutional policies and social structures. Given the multi-layered ways that gender can play a role in the workplace, it may take some effort to help health care workers understand and distinguish the topics.

Recommendations to shift perceptions and attitudes around gender in the workplace

- Assess participants' understanding of gender in the workplace and tailor training to their needs and the local context.
- Build in multiple opportunities for supervisors to learn about and explore issues of gender in the workplace.
- Engage health care providers in training on gender, provider bias, and male engagement in service delivery, and leverage this understanding to address gender in the workplace.
- Conduct research on changes in beliefs and attitudes around gender as a result of GTSS in diverse environments.

Implementation of GTSS

Coaches and supervisors described using the GTSS tool in their supervision visits, though provider recall of gender workplace issues discussed was somewhat limited and sometimes confused with issues related to client gender. While providers did not share information on gender barriers encountered in their workplaces, coaches did mention a few issues that came up during supervision visits.

The theory of change for GTSS in the Nigeria context hypothesizes that supervisors equipped with the appropriate training, a tool, and support from a trained coach will begin to shift their own attitudes around gender, initiate constructive conversations with supervisees, and address gender issues raised by their supervisees. The previous section with findings on gender perceptions suggests that LGA family planning coordinators were somewhat successful in understanding and challenging their own gender biases, while coaches were more successful—perhaps due to their prior exposure to gender concepts.

In terms of initiating conversations about gender with providers, the GTSS tool was designed to help supervisors raise and discuss gender workplace issues during supervision visits. Most coaches and supervisors mentioned using the tool in their supervision visits:

"I asked her some of the questions in that GTSS checklist just to know if she is doing well and if she has any problem even with her boss or with whatever that may be bothering her [and] that will not make her to have quality time to do her work . . . " — *LGA family planning coordinator, female, Akwa Ibom*

When asked during interviews about any gender issues they discussed in their recent GTSS sessions, providers' recall varied: some (9 providers) mentioned discussing issues related to their clients' gender, some (7 providers) indicated that they did not discuss any issues related to gender, while some (11 providers) described having touched upon issues from the GTSS tool:

"She [the LGA coordinator] brought a questionnaire like this [the GTSS tool] and was asking questions on gender roles and at the end of the day she gave me some commodities." — *Private facility provider, female, Akwa Ibom*

Of the 29 providers interviewed, none mentioned any gender barriers they had encountered in their workplaces during the interviews. The quantitative survey of 100 providers revealed that after GTSS visits, 87 percent of providers agreed with the statement that men and women are treated equally in their workplace (prior to GTSS, most were neutral on this issue). This response suggests that they may not have experienced gender discrimination. Only 7 percent of providers felt that their supervisors would perceive and treat them differently if they were of the opposite gender.

By contrast, in the focus group discussions, coaches (but not LGA family planning coordinators) shared a few issues they had encountered, mainly related to sexual harassment:

"I was able to know that the husband to the owner of the facility has been harassing the staff sexually and nobody could do anything, and the affected staff didn't know what to do . . . " — *Coach, female, Oyo*

Since they were not supervisors of the providers, coaches referred issues they encountered to LGA family planning coordinators or to SHOPS Plus. During the focus group discussions, coaches mentioned that they needed additional guidance on how to address any gender workplace issues that providers might raise.

Few private facility managers (who had received partial GTSS training) were willing to participate in focus group discussions. The discussion with the few who attended revealed potential considerations for GTSS implementation in a private sector context. Some private facility managers explained their preference for female providers, given their experience that female clients prefer female providers. Though client preference is not considered gender discrimination, if this preference results in hiring discrimination for providers

(male providers in this case), then this issue would be considered gender discrimination. Possible discrimination against male providers is not a new phenomenon in the nursing field (IntraHealth International, Nursing Now, and Johnson & Johnson 2019), as was affirmed in this assessment, with a male provider expressing the differential treatment he faced during his training:

"... we felt that the female gender were ... favored better than the male gender ... females facing exams pass better than males facing the same exam ..." — *Private facility provider, male, Oyo*

Coaches also suggested that fear of retaliation may be greater in the private sector, since they believe that termination happens more easily than in the public sector:

"... the person in the private sector most of the time is afraid of job security, unlike the person in the public sector ... it's easier to get information relating to the work environment ... from the person in the public sector." — *Coach, male, Akwa Ibom*

Lessons learned

Coaches and supervisors described using the GTSS tool in most supervision sessions, and over one-third of the providers remembered speaking about issues raised while using the tool. Limited recall by providers suggests that meaningful discussions on gender barriers in the workplace did not occur during every visit (though two sessions may not have been adequate). In terms of whether coaches had worked with providers to address gender-related issues that arose in supervision visits, providers were not forthcoming about whether this had or had not occurred, perhaps because they did not encounter any discrimination, they did not understand if they had, or they were not comfortable sharing this with researchers. They may have also been reluctant to raise issues for fear of appearing disloyal to those in their workplace. The fact that issues as serious as sexual harassment came up in conversations with coaches, yet were not identified in interviews by providers, suggests that providers who had encountered these issues were not included in our sample, or providers may be reluctant to discuss workplace gender issues, or may see them as normal. When implementing GTSS in a private sector context, implementation should address perceptions of retaliation.

Implications and recommendations

GTSS training and tools can be integrated into a broader supportive supervision effort, but to encourage consistent constructive conversations around workplace gender issues, supervisors and providers require ongoing support as

well as a foundational understanding of gender issues in the workplace. In the SHOPS Plus program in Nigeria, participating supervisors were asked to introduce a potentially controversial subject that they likely had never raised, along with assimilating new content related to clinical supportive supervision, gender, and GTSS. Increasing the number of visits by external supervisors in the early months after training could help build relationships between supervisors and supervisees and encourage constructive conversations on gender.

Both the supervisor and supervisee bring assumptions, expectations, and experiences affected by society's understanding of gender into supportive supervision conversations. Raising awareness among providers of potential gender-related issues in the workplace may be a critical element to increase their comfort in speaking about these issues. Supervisors also need tools to help providers solve problems in circumstances of sexual harassment, especially when these supervisors do not have power to address facility-level issues. GTSS implementation should include attention to structural factors that sustain gender inequality in the workforce, such as a facility's policies and practices on sexual harassment and paid leave, and a facility's compliance with national or state laws and policies. Targeting a mix of private and public sector supervisors and providers in GTSS may work better in some contexts than others, depending on existing relationships and protocols. Private facility managers may respond particularly well to market-based arguments in support of GTSS, particularly in terms of provider retention.

Recommendations for improved implementation of GTSS

- Precede implementation with a gender analysis to examine common gender barriers within the health workforce in the target geography, assessing differences in the private and public health workforce as relevant.
- Develop a GTSS tool appropriate to the local context using language that is locally familiar and including questions related to gender barriers identified in the gender analysis.
- Provide ongoing support to supervisors after GTSS training to ensure that meaningful conversations about gender in the workplace are occurring (in line with the GTSS conceptual framework), that visits are completed, and that any issues raised by providers are addressed.
- Incorporate companion training for providers on gender issues in the workplace.
- Coordinate with authorities to analyze and reform facility policies and protocols to advance gender–friendly workplaces while protecting providers against retaliation; provide supervisors with clear guidance on how to respond to serious safety issues such as sexual harassment.
- For projects that use public sector supervisors in the private sector, work with private sector facilities in advance to establish parameters, define mutual benefits, and ensure agreement by leadership.
- Develop a business case that documents the advantages of GTSS from a private sector perspective to market the approach to managers of private facilities.

Provider outcomes of GTSS

Both public and private providers described positive outcomes of GTSS related to their job satisfaction and communication with supervisors. These outcomes appear to be mostly related to the supportive supervision aspects of the GTSS visits, though some providers indicated that discussions on gender influenced the positive outcomes they experienced.

Almost all providers who participated in interviews described increased job satisfaction after their supervision visits. They cited reasons related to improved skills, positive feedback from the coaches and LGA family planning coordinator, their ability to perform better at their jobs, and increased confidence in their skills. Almost all providers who were interviewed also indicated that they felt that GTSS had improved their job performance, explaining that this was due to their new skills (from the family planning training) and subsequent supportive supervision. Constructive feedback, in the context of supportive supervision and new skills, was welcomed by providers and contributed to their overall sense of satisfaction in their jobs:

"There is a boost; once interaction is better, the overall job satisfaction too will certainly come up." — *Private facility provider, Oyo*

Our survey of providers revealed a marked increase in job satisfaction before and after GTSS—with an increase from 15 percent agreement with a statement that they were satisfied or content in their job before supervision visits to 92 percent after they had two GTSS visits.

During interviews, providers were asked specifically about how GTSS may have influenced their communication with the LGA family planning coordinators (their external supervisors). Many (19 of 29) providers described improved communication with the LGA family planning coordinator, and some explained how this had allowed them to discuss challenges more openly:

"It has made us to be more close and friendly. I can discuss freely with them about the family planning and other issues." — *Private facility provider, Akwa Ibom*

Some private providers, some of whom owned their facilities, did not see GTSS as having improved their communication with the LGA family planning coordinators. This may be because they have limited interaction with the coordinators, or they felt that their communication was already effective and did not require improvement. For some private providers, supervisory visits from the LGA family planning coordinators helped establish public sector linkages to family planning service delivery in the private sector, which they valued:

"Well, it has changed in the sense that before, the LG[A] coordinator has not been all that [focused on] familiarizing herself with us compared to after the supportive supervision visits. In fact, she calls virtually every week; we are now on the platform together . . . they keep us informed compared to before." — *Private facility provider, Oyo*

A few providers suggested that addressing gender in their supervision visits had influenced the positive outcomes they experienced. One provider explained how:

" . . . our work is teamwork; we don't look at who is a woman, who is a man. We work together and the outcome is our vision and mission and we are able to achieve it." — *Private provider, male, Oyo*

From the perspective of coaches and supervisors, the supportive supervision skills they acquired were valuable, particularly in changing how they communicated with providers. A number of coaches and LGA family planning coordinators explained how the GTSS training changed the way they gave feedback and solved problems with providers, shifting from a largely antagonistic approach to more collaborative, supportive communication:

" . . . we are not going to witch-hunt or to observe negative things alone . . . when I get there I always let them feel free, we crack jokes—you know, to relieve tension . . . " — *LGA family planning coordinator, Oyo*

Lessons learned

Our assessment endorses the belief that supportive supervision that is truly supportive, interactive, and collaborative can lead to positive outcomes among providers. While our assessment was not designed to evaluate the impact of the gender aspect of supportive supervision, a few providers cited its influence.

Also worth noting in the program context is that government supervisors (the LGA family planning coordinators) were supporting private providers. This support was valued by some of these providers, where positive provider outcomes ultimately benefit their clients as well as the owners of private facilities.

Implications and recommendations

Health care providers perform better and enjoy their jobs more when they have the right skills and encouragement from a respected professional. As found elsewhere, supportive supervision interventions that focus on interpersonal relationships, constructive feedback, and joint problem solving are effective at improving service quality and provider retention. Although it was not this assessment's intention to compare GTSS to gender-blind approaches, integration of gender into supportive supervision activities does not appear to interfere with these outcomes. Even in contexts where gender has not previously been discussed in the workplace, GTSS may contribute to enhanced relationships between supervisors and health care providers.

Private providers can benefit from public sector oversight of the quality of their service provision. However, public sector coaches and supervisors have no control over gender-related barriers within private sector workplaces. To reap the full benefits of the gender-transformative elements of GTSS, private providers need on-site allies who are amenable to creating gender-friendly workplaces and channels, such as provider associations, to work on improving workplace policies and practices.

Recommendations for achieving positive provider outcomes with GTSS

- Ensure GTSS includes training for supervisors on traditional supportive supervision elements around communication, positive feedback, and collaboration, along with clinical supervisory skills.
- In facilities where private sector providers are working with public sector supervisors, ensure that they also have on-site supervision or other support trained in GTSS.

Assessment limitations

The generalization of the results of this assessment is limited in the following ways:

- This model of operationalizing the GTSS conceptual framework is only one potential approach, adapted to this programmatic and geographic context. The findings of this assessment may or may not apply to other models of implementation.
- All assessment and program participants (including providers, coaches, and supervisors) were newly trained on providing or supervising the delivery of family planning methods and were experiencing supportive supervision for the first time. As a result, it is not possible to attribute the outcomes observed in this assessment solely to the gender (GTSS) module implemented as a part of the overall SHOPS Plus training intervention.
- External supervisors conducted GTSS visits, not the internal supervisor of providers, who may have a greater influence on the provider's work environment.
- Providers received only two GTSS visits over the three-month period in which data for this assessment were collected. While it was hoped that LGA family planning coordinators would continue to incorporate GTSS elements in their future supervision, the program did not have the resources to send coaches to support additional visits. Additional time and interaction between providers, coaches, and supervisors may have resulted in improved relationships, discussion on gender-related topics, and outcomes.
- Providers may not have felt comfortable discussing potentially sensitive issues with researchers.

Conclusion

Achieving gender equity in the health workplace will require multiple coordinated strategies that promote professional development and women's leadership, address social norms and perceptions of gender, and promote structural changes and policies to address gender discrimination and sexual harassment in the workplace. GTSS—or another form of gender-intentional supportive supervision—can play a role in creating gender-equitable workplaces. When implemented appropriately, GTSS can address gender-related barriers to performance and job satisfaction by guiding supervisors to oversee their supervisees without bias and to have constructive conversations about gender barriers. Effective implementation of GTSS includes consideration for the supervisory context, the background of supervisors and providers, and the complexity of understanding gender barriers in the workplace. Also, GTSS should include strong supportive supervision, which on its own appears to promote positive provider outcomes. Accompanied by structural and policy changes in the workplace and beyond, GTSS could contribute to improved quality of care for clients and ultimately to a more equitable workplace for providers in the public and private health sectors.

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Gender–transformative supportive supervision can address gender–related barriers to the performance and job satisfaction of health care providers.

Photo: KC Nwakalor

Annex. Gender-Transformative Supportive Supervision Tool

Supportive supervision is based on the establishment of mutual trust and constructive communication between the supervisor or coach and the health care provider. When conducting a visit for supportive supervision, it is important to consider the ways gender norms and power dynamics might affect interactions between supervisors and health care providers. Anticipating any potential issues in advance can help ensure the visit goes smoothly and that you have the best opportunity for successfully working together to improve quality of care.

Gender refers to the expectations, roles, and responsibilities that society assigns to individuals based on being male or female. Research has shown that in the workplace, just as in society at large, gender-based biases or preconceptions can affect experiences on the job and interactions among employees, especially among supervisors and supervisees.* **Gender biases can lead to gaps between male and female health workers in terms of promotion, pay, job satisfaction, and retention. Supportive supervision visits present an opportunity to explore and address the influence of gender dynamics on the work environment and supervisor-health care provider interactions.**

Prior to your visit

Think about perceptions or biases you may have about men and women in the health workplace:

- Do you think that men and women have different "natural" skills or traits because of their biological sex (such as leadership skills, compassion, or attention to detail)? Are these perceptions always accurate? How might these perceptions affect your interactions with health care providers?
- Do you think that men and women have different needs for income from their jobs? Do you think that men and women have different needs for time off for family commitments? If so, how might that affect your expectations of their professionalism, their ability to work for little or no pay, or their need for flexibility in work hours?
- In general, do you communicate differently with men than women? If so, how might that affect supportive supervision conversations with each?
- In general, do you respond differently to feedback from men than women? If so, how might that affect supportive supervision conversations with each?
- Is your feedback received differently by men or women? If so, how might you work with a provider to reduce the influence of gender on your conversations?

*See the brief, "A Conceptual Framework for Gender-Transformative Supportive Supervision" for more information.

During your visit

Providers have some background in understanding how gender may affect service to their clients, but likely have spent less time thinking about how gender can affect how they themselves are perceived, promoted, compensated, and treated on the basis of being a man or woman.

- ❑ Start by saying, "Up until now, our conversation has focused mainly on technical skills and quality of care. We know that gender norms can affect client experiences and their access to family planning, but also, gender can affect you as a provider and your opportunities and experiences as a health worker. Gender can affect how you and I communicate, how successful you are in your job, and how much you want to continue being a health care provider."
- ❑ Tell the provider, "As your coach (or supervisor), I want you to know that this conversation is a safe space for you to discuss any experiences you have had, or talk about any harassment or discrimination in the workplace. You will not be punished for anything you have to say."
- ❑ Tell the provider, "I'm going to ask some questions to find out if you've experienced any gender discrimination or problems related to gender as part of your job. Then we can develop solutions to address these problems together. Do you have any questions before I begin?"

Instructions: Ask all the following questions on your FIRST visit with a provider. On the next visit, only ask the questions that are marked with an asterisk (*). Adjust the language as necessary for a male or female provider. Note the answers to the questions in the space provided. After completing the questions, note any issues that require problem solving or follow up at the bottom of this form.

Gender discrimination

Do you feel your coworkers treat you the same as [male/female] employees of your same cadre?

Do you feel your superiors treat you the same?

Do you feel I treat you the same?

Are you paid the same as peers in your cadre?

Upward mobility

What are your performance and career goals?

*Do you feel you have the support you need in this position to help you reach your performance and career goals?

Do you feel you have the same promotion opportunities as [male/female] employees of your same cadre?

*Is there anything I can do differently to help you reach your performance and career goals?

*Is there anything those in charge of this health facility can do differently to help you reach your performance and career goals?

Do you feel like you have access to enough professional development opportunities, such as training? If not, is there anything we can do differently to make sure you have access?

Facility policies

*Has anyone told you about what this facilities' policies are related to sick leave, maternity or paternity leave, breastfeeding, or sexual harassment? If yes, which policies have you been told about?

*Do you feel the facility's policies treat you the same as your [male/female] coworkers?

*Do you ever feel the facility's policies get in the way of your productivity or security on the job?

Sexual harassment

Before asking these questions, make sure you are in a private location. Remind the provider that they will not be punished for reporting any sexual assault or harassment.

*Has anyone—a coworker or client—ever treated you in a way that made you feel unsafe?

*Has anyone—a coworker or client—ever touched you inappropriately or spoken to you in a sexually explicit way without your consent?

*Has anyone—a coworker or a client—ever suggested that engaging in a sexual act with him or her would protect or advance your career?

Travel and safety

*If you have to travel for work, do you ever feel your travel or lodging arrangements are not safe?

*Do you ever feel that being [male/female] puts you in a more dangerous situation while you are working?

Do you have any suggestions about how to make your job safer?

Note any issues discussed and how you and the provider will work together to resolve them:

Note any issues that require **immediate attention**, particularly safety or sexual harassment issues:

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development. The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan.

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