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Adapting and Implementing the Beyond Bias Model: Solutions to Reduce Provider Bias in Contraceptive Service Delivery for Youth and Adolescents



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Who is This Guide for and How Do I Use It?

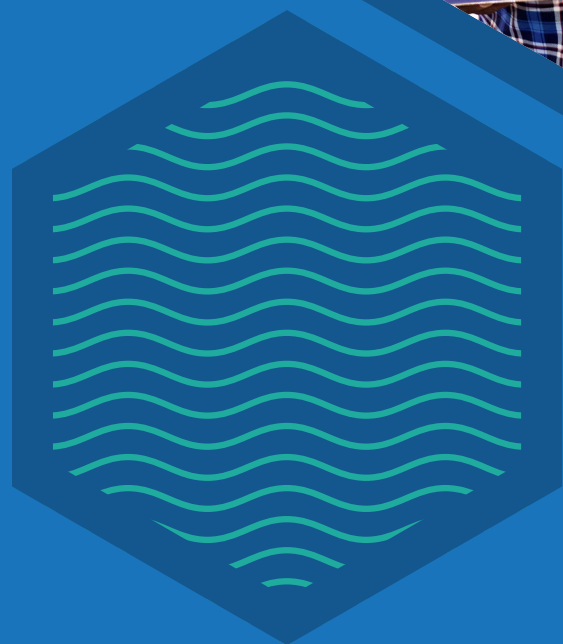
This guide was designed and written for many different audiences as shown in the table below:

I am a...	Why should I read this guide?	Which sections should I focus on?
High-level government decision-maker (e.g., MOH department or unit head of an FP/RH, AYSRH, RMNCH, or similar program)	Because provider bias is an issue in my country/setting that is hindering delivery of adolescent and youth sexual and reproductive health (AYSRH) services. I would like to explore the Beyond Bias approach and determine if it is a model my country should adopt to help overcome the challenge of provider bias as it relates to AYSRH.	Section I
National (government) program implementer, for example a MOH program officer working at national or subnational levels	Because my Ministry intends to adopt/integrate the Beyond Bias model into our existing national program and I will be supporting its implementation. I need to understand what the approach is and what the options are for Beyond Bias adaptation, integration, and implementation using public sector resources.	Sections I and II of this guide, plus the additional resources included in the annexes.
Donor agency decision-maker looking to support national partner(s) in mitigating provider bias	Because provider bias hinders delivery of AYSRH services in countries/settings where my agency provides technical and/or financial support. I would like to explore the Beyond Bias approach and determine if it is a model that my agency can recommend for application in settings we support.	Section I
Member of a donor-funded implementing agency (e.g., NGO, INGO, community-based organization) or private franchise working with reproductive health providers	Because my agency intends to implement the Beyond Bias model and I will be supporting its adoption, adaptation, and implementation. I need to understand what the approach is and how to roll it out in a particular country setting, using donor-provided resources.	Sections I and II of this guide, plus the additional resources included in the annexes.

A few items to note before continuing reading:

For those seeking additional resources on Beyond Bias that have not been included within this document, a list of supplemental readings have also been included in the annexes.

Regarding terminology used in this document: The name “Beyond Bias” refers to both the Bill & Melinda Gates Foundation-funded multi-country project led by Pathfinder International and the behavior change model that resulted from that project. Throughout this guide, references to “the Beyond Bias project/team” describe past experiences the project had in developing, testing, and implementing the model in Burkina Faso, Pakistan, and Tanzania. In contrast, references in this guide to the “Beyond Bias model/approach/solution” point to the behavior change strategy itself, separate from the project.



SECTION I:

**Is the Beyond Bias
Model Right
for My Setting?**

Why is Provider Bias a Problem?

Preventing unintended pregnancy is essential to improving adolescents' sexual and reproductive health and their social and economic well-being.

About half of pregnancies among adolescent women aged 15–19 living in developing regions are unintended, and more than half of these end in abortion, often under unsafe conditions. Modern contraception plays a crucial role in allowing women to control the timing and number of their pregnancies. Yet, out of 32 million adolescent women in LMICs who want to avoid a pregnancy, 14 million (43%) have an unmet need for modern contraception.¹ Research shows² that provider bias and judgmental behavior is a major barrier to the use of contraception by young people, including newly marrieds and first-time parents.

Decades of training and supervision have been insufficient in addressing biases held by sexual and reproductive health providers. Recognizing this reality, the Beyond Bias project was conceived with a mandate to disrupt the status quo by developing new innovative solutions to address this enduring barrier to care.

¹ Sedgh G. et al. 2016. Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method. New York: Guttmacher Institute.

² See:

Warenius L.U., et al. 2006. Nurse-midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia. *Reprod Health Matters*. 14(27):119-28.

Wood, K and Jewkes, R., 2006. Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa. *Reproductive Health Matters*. 14:27, 109-118.

Tilahun, M., et al. 2012. Health Workers' Attitudes toward Sexual and Reproductive Health Services for Unmarried Adolescents in Ethiopia. *Reproductive Health*. 9, 19.

Calhoun, L.M., et al. 2013. Provider imposed restrictions to clients' access to family planning in urban Uttar Pradesh, India: a mixed methods study. *BMC Health Services Research*. 13, 532.

Chandra-Mouli, V., et al. 2014. Contraception for adolescents in low and middle income countries: needs, barriers, and access. *Reproductive Health*. 11, 1.

What does bias look like?

Multiple barriers prevent youth from accessing the contraceptive method of their choice. Many AYSRH programs focus on helping youth overcome barriers, such as social stigma, that prevent them from going to health facilities. Provider bias, however, occurs at the point of service. The few minutes a young person spends with a provider can have long-term consequences on the client's health, education, and future.

Beyond Bias's formative research found that specific biases manifest differently from country to country and from provider to provider, though overarching commonalities do exist between settings. In some cases, bias may prompt a provider to avoid counseling youth about long-acting reversible contraceptives (LARCs) and hormonal methods or to refuse service altogether for unmarried clients. In another setting, bias may motivate a provider to only promote abstinence as a family planning method to unmarried youth. In yet other settings, provider bias may result in a denial of LARCs to nulliparous clients or a requirement that a youth client obtain spousal or parental consent before services will be provided. Though the specifics may vary, a common outcome of provider bias is that youth clients are discouraged from accessing and utilizing sexual and reproductive health products and services.

“If you don’t meet youth in family planning, you meet them in labor.”

—Nurse participant in Beyond Bias prototyping, Tanzania

Why Should I Adopt the Beyond Bias Approach?

As implemented in Burkina Faso, Pakistan, and Tanzania, the Beyond Bias project led to a significant reduction in biased attitudes and beliefs among providers in all three countries and to more comprehensive counseling and better perceived treatment of young family planning clients in Tanzania and Pakistan.

As documented in Beyond Bias' external evaluation report, the project's results contribute to the global evidence base that negative provider biases can be shifted in favor of attitudes and beliefs that support youth in accessing sexual and reproductive health care.

As a result of the implementation context*, limited evidence was found in the evaluation that Beyond Bias' intervention produced significant levels of change in FP method uptake, types of FP methods received by clients, or likelihood that youth clients



AS IMPLEMENTED IN BURKINA FASO, PAKISTAN, AND TANZANIA, THE BEYOND BIAS PROJECT RESULTED IN:

A significant reduction in biased attitudes and beliefs among providers in all three countries.

More comprehensive counseling and better perceived treatment of young family planning clients in Tanzania and Pakistan.

Compelling insights and lessons learned about the limitations of current tools used to measure provider bias and client experience of bias.

received their method of choice (see evaluation report for a full discussion on results). Despite this, positive effects of the intervention are still critically important given that improved provider attitudes and beliefs, improved counseling quality, and improved client experiences are all results anticipated to influence more young women to seek FP care in the future. Current disparities in FP uptake appear to exist because many young women avoid clinics altogether, out of fear of experiencing bias. For example, across the three Beyond Bias countries, only 8% of clients seeking care at facilities were age 15-19 and only 6% did not have a child. In Pakistan, fewer than 1% of clients were unmarried. Adoption/integration of the Beyond Bias approach within national AYSRH programs may, over time, result in more young women who traditionally avoid FP clinics successfully accessing high-quality care. This may be especially so if bias reduction solutions are paired with complementary demand generation/community outreach activities. Lowering barriers for young, hard-to-reach, underserved women is an important step toward reducing disparities and achieving universal health care.



*The relatively high rates of FP uptake that already existed within Beyond Bias project clinics, most likely a result of layering the intervention on top of existing AYSRH projects, in addition to having no demand generation activities to disseminate the intervention within the community, meant that the Beyond Bias project did not have a lot of room for improvement within the 1-year timeframe. In contexts where there is significant room for improvement, this model when combined with demand generation activities has the potential to improve FP uptake in the long run.

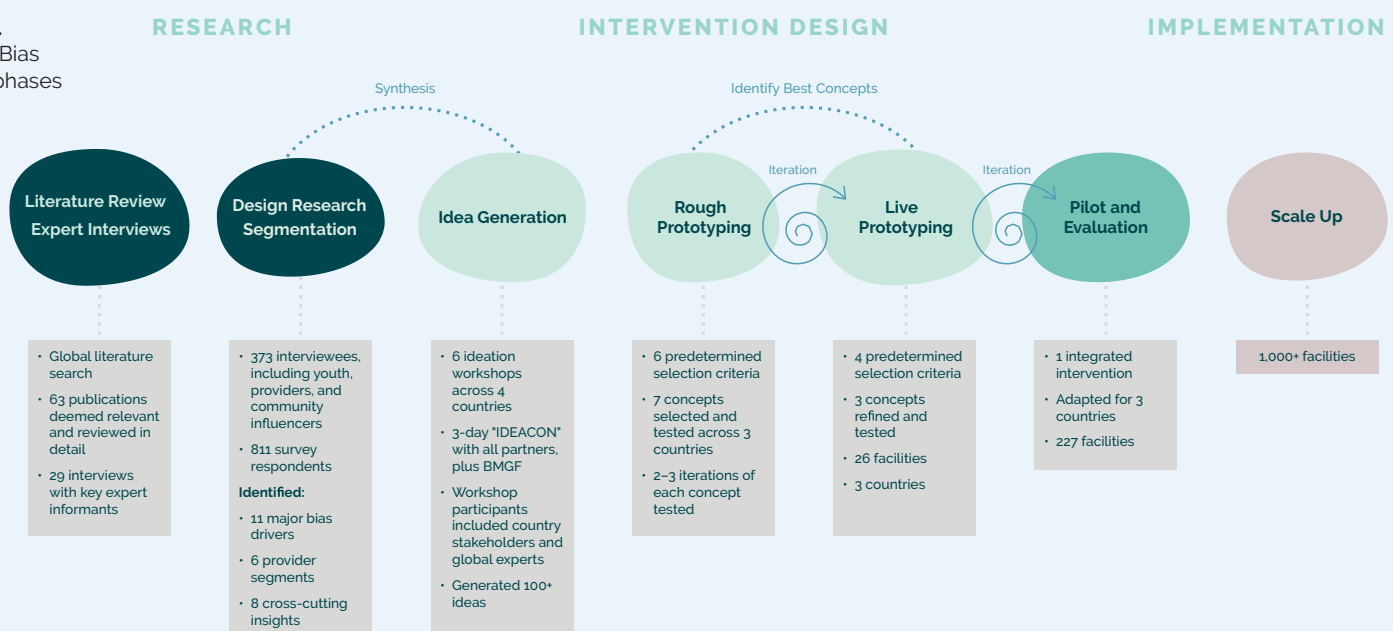
Introduction to Beyond Bias

Beyond Bias was a multi-country project that sought to ensure that young people between 15 and 24 years of age have access to empathetic, non-judgmental, high quality counseling and provision of a full range of contraceptive methods regardless of their marital status or parity. Led by Pathfinder International, in collaboration with Camber Collective, YLabs, and RAND and supported by funding from the Bill & Melinda Gates Foundation, Beyond Bias used human-centered design (HCD), psycho-behavioral segmentation, behavioral economics, and social and behavior change (SBC) principles in designing and testing innovative, scalable solutions that address provider biases.

The Beyond Bias project's hypothesis was that by understanding what drives provider bias (defined as negative attitudes or beliefs that manifest in judgmental, non-empathetic, and/or low-quality provider behaviors), small changes can be made to shift these biases and to thus remove provider-related barriers youth face when attempting to access sexual and reproductive care. If provider-related barriers can be removed, then young people will feel more confident and capable to make fully informed decisions around contraceptive use and will receive the contraceptive method of their choice (including long-acting reversible methods), ultimately leading to increased uptake of contraceptive methods.

Using a comprehensive, multi-stage design approach that included extensive research, prototyping, iteration, and evaluation phases (FIGURE 1), the Beyond Bias project worked with hundreds of public sector, private sector, and community stakeholders in Burkina Faso, Pakistan, and Tanzania to develop the Beyond Bias behavior change approach. Scale up, as shown below, will occur in the future, after the term of the Beyond Bias project.

FIGURE 1.
Beyond Bias
project phases



What Drives Provider Bias?

The Beyond Bias project identified **11 key global drivers of bias** (shown at right) through a comprehensive literature review and formative research process involving **900 providers, youth, and community leaders in Burkina Faso, Pakistan, and Tanzania.**

The project discovered that, while providers in the three countries shared the same drivers of bias, bias manifests differently across settings. The roots of provider bias in Burkina Faso were found to be largely situational and structural, whereas biases in Pakistan stemmed more from social norms and values. In contrast, in Tanzania, provider biases were found to be influenced more by biographical, situational, and cultural factors. How this translates to real-world clinical settings is that newly married young women who have not had a child yet may be denied family planning services in Pakistan due to provider bias around the importance of proving one's fertility within marriage, whereas in Tanzania, providers may commonly deny contraception to clients they deem to be "too young", engaging in "bad behaviors", or who are still in school.

WHY DOES THIS MATTER?

Understanding and contextualizing the drivers for your specific setting will help ensure that the right amount of emphasis is placed on specific components of the Beyond Bias approach. Tailoring your approach to your particular audience is more likely to lead to behavior change impact.

KEY DRIVERS OF PROVIDER BIAS:

- 1. Negative attitudes** Perception that sexually active youth are reckless/bad
- 2. Unwillingness to change** Adherence to outdated modes of serving clients
- 3. Difficulty communicating** Discomfort or lack of experience talking with youth about sex and sexuality
- 4. Product inexperience** Lack of experience with or knowledge about a specific contraceptive method
- 5. Lack of motivation** Perceived lack of recognition or incentive to provide quality services to youth
- 6. Workload** Demanding schedule that inhibits provision of quality care, especially to youth
- 7. Workplace norms** Culture that does not prioritize young clients' needs
- 8. Clinic reputation** Fear that offering youth contraceptive services will affect community perception of the clinic
- 9. Competing SRH risks** Concern that giving youth contraception will encourage promiscuity, increasing risk of STIs or HIV
- 10. Social norms** Social stigma against young, unmarried, sexually active women; fear of fertility-related contraceptive side effects
- 11. Personal attributes** Provider's use of a specific contraceptive method or perspective as a parent of an adolescent

The Beyond Bias Behavior Change Strategy

The Beyond Bias intervention was designed to support health care providers at every phase of their journey from developing awareness of their own bias to becoming advocates for improved contraceptive services for youth in their community.

The Beyond Bias behavior change strategy is that if providers are supported by a community of peers and trusted experts to activate their motivation and self-awareness of bias; apply knowledge and motivation toward eliminating bias from their work; and achieve recognition for improved performance, then the quality of FP/SRH care they deliver to youth clients will improve.

As shown in **FIGURE 2** below, the Beyond Bias behavior change strategy integrates three solutions: Summit, Connect, and Reward. The intervention is grounded in evidence and behavior change theory, and uses the Stages of Change behavioral model as an underlying theoretical framework.

FIGURE 2. Beyond Bias Behavior Change Strategy



Graphics: Ylabs

The Three Pillars: SUMMIT, CONNECT, REWARDS

The Beyond Bias intervention is designed to shift providers' negative attitudes and behaviors through a three-pronged approach. The three parts—Summit, Connect, and Rewards—reinforce each other across the continuum of care.

Summit is a story-driven, in-person, one-day event that activates providers' awareness of their own biases and their empathy for young people's needs. Summit's core elements include the following:



SUMMIT: Core ingredients for success



Personal, emotional stories shared by youth and other providers.



Professional permission to serve youth given by respected authority figures.



Guided reflection activities to support providers to own their biases.



Individual action planning and public commitment to put motivation into action.

Connect is an ongoing peer-support and learning forum—conducted either virtually via WhatsApp, in person, or with a hybrid model—in which providers problem-solve together to apply unbiased practices in their daily work. Connect's core elements include the following:



CONNECT: Core ingredients for success



Realistic case studies of youth clients drive discussion with peers and providers' application of knowledge to their daily work



Trusted technical experts and practical tips dispel medical misinformation and increase credibility of the content in providers' eyes



Safe space to share struggles and successes with peers creates group identity and belonging



Regular review of unbiased service delivery goals supports providers to maintain motivation and group commitment

Finally, **Rewards** is a growth-oriented non-monetary performance-based incentive assessed through client feedback on provider behavior. Rewards recognizes providers in front of their peers when they achieve improvements in service quality to youth. Facilities receive report cards with performance data and recommendations for improvement, and those with high improvement scores get public recognition for their progress. Rewards' core elements include the following



REWARDS: Core ingredients for success



Together, the **three parts** reinforce each other across the continuum of care.



SUMMIT



CONNECT



REWARDS

Graphics: Ylabs

The Six Principles of Unbiased Care

The Six Principles of Unbiased Care (FIGURE 3), derived from the World Health Organization's (WHO) quality of care principles³ and further developed through discussions with global AYSRH experts, inform the Beyond Bias model's standards for “unbiased care”.

The principles provide a framework for providers seeking to deliver unbiased care to their clients. The principles are: (1) providing a safe, welcoming space; (2) engaging in sensitive communication; (3) seeking understanding and agreement; (4) saying yes to a safe method; (5) offering simple, comprehensive counseling; and (6) ensuring security of client information. Each principle corresponds to specific, measurable provider behaviors.

FIGURE 3.
Six Principles of
Unbiased Care



Graphic: Ylabs

³ https://www.who.int/health-topics/quality-of-care#tab-tab_1



Within the Beyond Bias approach, providers are introduced to the Six Principles during the Summit stage. They then work to apply the Six Principles during the Connect phase. Finally, providers' achievements toward adopting the Six Principles are recognized during the Rewards stage.

Key steps in the process include:



SUMMIT

Providers learn about the Six Principles of Unbiased Care framework through presentation and discussion.

Facilitators guide providers through reflection activities on the Six Principles.

Each provider receives a Six Principles booklet and poster.



CONNECT

Case study discussions deepen providers' practical understanding of the Six Principles.

Trusted technical AYSRH content helps providers understand method types and appropriateness.

Facilitators guide teams to identify collective actions they can take (where applicable) that align with the Six Principles.



REWARDS

Quarterly report cards outline data on how well facilities are performing on each of the Six Principles.

Facilities that improve their performance on the Six Principles are celebrated quarterly.

Facilities receive recommendations for actions they can take to improve performance on the Six Principles.

Graphic: Ylabs

What Does Success Look Like?

1

2

3

4

Provider adopts this principle of care:	Resulting in a provider commitment to:	And an adoption of desired behaviors including:	As a result, youth clients are able to:
SAFE, WELCOMING SPACE	<p>Work with all facility staff to create a safe, welcoming space for all youth regardless of wealth, gender, age, parity, marital status, ethnicity, or religion.</p> <p>Respect and value youth who come to the clinic seeking contraception, for taking a positive step to protect their health and ensure their success.</p>	<p>Approaching all adolescents, including those from marginalized and vulnerable populations, in a non-judgmental and non-discriminatory manner, respecting individual dignity</p> <p>Informing youth about their rights to seek respectful health services, including contraception, and to give feedback on those services.</p> <p>Working with all facility staff to create a safe, welcoming space for all youth.</p>	<p>Feel welcomed by all clinic staff.</p> <p>Freely express feedback on services received Feel respected and not judged for seeking contraception.</p>
SENSITIVE COMMUNICATION	<p>Communicate clearly, respectfully, and compassionately with all youth, so they can easily understand medical information and freely voice questions and concerns.</p> <p>Listen attentively and respond to young people's needs, concerns, and questions.</p>	<p>Active listening and giving time for questions.</p> <p>Showing compassion, reassurance, and non-authoritarian communication.</p> <p>Giving information about what will happen during the clinic visit, including physical examinations, tests, treatments.</p> <p>Encouraging voicing of client questions about services and responding clearly.</p>	<p>Ask questions of the provider and receive clear answers.</p> <p>Understand what will happen during the clinic visit.</p>
SEEK UNDERSTANDING AND AGREEMENT	<p>Check client understanding before providing appropriate care.</p> <p>Recognize the individual right of all youth to accept or refuse treatment, testing, and physical examination.</p>	<p>Explicitly checking youth understanding of services to be provided.</p> <p>Seeking verbal agreement from youth for services provided.</p> <p>Understanding information given by the client.</p>	<p>Obtain information needed to make an informed choice.</p> <p>Feel ready and able to make and express their choice to the provider.</p>

CONTINUED

Provider adopts this principle of care:	Resulting in a provider commitment to:	And an adoption of desired behaviors including:	As a result, youth clients are able to:
SAY YES TO A SAFE METHOD	Provide youth with their chosen methods of contraception regardless of age, parity, or marital status, in line with World Health Organization guidelines.	<p>Providing medically appropriate, patient-centered services that take individual medical history and status into account, regardless of client age, parity, or marital status.</p> <p>Giving clear and accurate information on method use and side effects.</p> <p>Assisting clients if they wish to change or discontinue a method.</p> <p>Ensuring follow-up as needed.</p> <p>Providing the method of choice after comprehensive counseling.</p>	<p>Obtain contraception for a non-medical reason.</p> <p>Understand how to use the method correctly and common side effects.</p>
SIMPLE, COMPREHENSIVE COUNSELING	<p>Provide accurate information on a range of modern contraceptive methods, including long-acting reversible contraceptives (LARCs) and emergency contraception (EC), in jargon-free language that youth can understand.</p> <p>Give youth information they need to make free, informed choices, without pressure or bias, to choose one method over another.</p>	<p>Presenting a range of modern contraceptive methods, including LARCs and EC.</p> <p>Counseling using language that youth can understand.</p> <p>Asking which method, if any, the young person would like to choose.</p> <p>Avoiding pressuring or biasing youth in their decision-making.</p> <p>Addressing in full young people's questions, fears, and concerns regarding contraceptive methods.</p>	<p>Choose from among a choice of contraceptive methods, including LARCs and EC.</p> <p>Understand information given.</p> <p>Feel their concerns were addressed and make informed choices.</p> <p>Feel no pressure to choose one method over another.</p>
SECURITY OF INFORMATION	Ensure that all facility staff respect the confidentiality and privacy of youth seeking care.	<p>Informing youth about their right to privacy and confidentiality.</p> <p>Taking active steps to deliver care privately, so others cannot see or overhear their consultation.</p> <p>Keeping client information confidential, except when clinically indicated.</p> <p>Providing private, confidential care.</p>	Be seen and treated in a private place where others cannot see or overhear their consultation.



IMPACT

Clients receive the method of their choice

Clients are treated in a non-judgemental, non-biased manner

Clients are counseled on a full range of modern methods

Designed for Scale-up

Beyond Bias employed the WHO/ExpandNet framework to ensure that we designed and pilot tested the model with scale in mind from the start

Based on a framework put forth in ExpandNet's 2009 *Practical Guidance for Scaling Up Health Service Innovations*, "innovations with the features listed below are most likely to be successfully transferred:

- *Credible, in that they are based on sound evidence or advocated by respected persons or institutions;*
- *Observable, to ensure that potential users can see the results in practice; Relevant for addressing persistent or sharply felt problems;*
- *Relative advantage over existing practices so that potential users are convinced that the costs of implementation are counteracted by the benefits;*
- *Easy to install and understand, rather than complex and complicated;*
- *Compatible with the potential users' established values, norms and facilities; fit well into the practices of the national programme;*
- *Testable without committing the potential user to complete adoption when results have not yet been seen."*

As described earlier, we followed a rigorous, multi-year design, development, and refinement process in arriving at the Beyond Bias approach explained in this guide. In addition to conducting extensive testing and refinement cycles, we formed coalitions of engaged stakeholders (also referred to as "resource teams") in each Beyond Bias country, to work with us, guide us, advocate for and with us, and carry the Beyond Bias message on even after the project ended. High-level Advisory Committees which convened regularly were instrumental in helping country teams achieve their objectives. Resource teams the project engaged in each of the three countries are shown in **FIGURE 4**.

FIGURE 4.

Resource teams in each country included stakeholders at facility, district/regional, and national/international levels.

Resource Team	Pakistan	Burkina Faso	Tanzania
FACILITY	Private sector providers	Public sector facility managers (MOH)	Public sector facility managers (MOH)
DISTRICT/ REGIONAL	Greenstar Quality Assurance managers	Association des Municipalités du Burkina Faso (MOH)	District and Regional Health Management team (MOH)
COUNTRY/ MULTI-REGION	UNFPA, CIP Cell, Aahung, ShirkatGah, IPAS, Marie Stopes Society, Society of Obs and Gyn / NCMNH, BMGF representative, Aga Khan	Direction de la Sante de la Famille (MOH), UNFPA, Groupe Technique SR, CAPSSR-BF, Mouvement d'Action des Jeunes	National Institute of Medical Research, Adolescent Reproductive Health Coordinator (MOH), UNICEF, PSI Aga Khan, YUNA, Msichana Initiative, HOPE Centre

Adapting and Institutionalizing the Beyond Bias Model in Your Setting

A critical factor in adopting, scaling, and eventually institutionalizing an intervention or program successfully is understanding which of its elements require fidelity and which can be adapted depending on the context.

Within the Beyond Bias model, the following elements require **fidelity**:

- | | | |
|--|---|--|
| <ul style="list-style-type: none">• Behavior-change mechanisms• Personal, impactful stories shared by youth and other providers• Professional permission to serve youth given by respected authority figures• Guided reflection activities to encourage providers to own their biases• Individual action planning and public commitment to turn motivation into practice | <ul style="list-style-type: none">• Enabling environment• Safe space for providers to express concerns and struggles• Motivational and collaborative learning environment• Endorsement from respected authority figures (professional and community)• Technical expertise and practical tips that dispel misinformation | <ul style="list-style-type: none">• Review and feedback, given regularly for reinforcement over time• Regular review of unbiased service delivery goals based on the Six Principles of Unbiased Care• Client feedback, captured directly after counseling• Institutional recognition for improvement and maintenance of quality |
|--|---|--|

The delivery format of many Beyond Bias components, however, can be **adapted** as needed to better fit with local needs, to accommodate local constraints, and to facilitate institutionalization within ongoing programs. For example:

Summit and Connect content can be divided into multiple sessions and integrated into other health care training or capacity strengthening activities. For example, training on the Six Principles of Unbiased Care framework can be integrated within provider in-service family planning training packages and continuous learning/license renewal programs.

Summit can also be institutionalized in pre-service training packages for health care providers. Summit can be included in curricula for nursing, midwifery, and medical schools so that new graduates enter the health system conscious of provider bias (and its ill effects) and committed to providing unbiased care in their own practices.

Summit and Connect content can also be incorporated into monthly facility-based staff meetings and other institutional venues where continuous quality improvement is monitored and discussed.

For Rewards, data collection modalities can be changed. For example, client exit surveys can be completed quarterly by community health workers or mentors at district level, rather than by paid enumerators. Further, digital data collection could be an option in some contexts in the near future with advances in mobile phone access and use. Another option would be use of mystery clients in contexts where actual client volume is persistently low.

Rewards ceremonies can be held less frequently (for example semi-annually or annually) if a quarterly schedule isn't feasible.

What if I Can't Adopt the Whole Beyond Bias Model Yet? Are There Still Things I Can Do Today?



- Including bias reduction objectives in national FP/AYSRH policies and strategies, as well as in annual FP/AYSRH program work plans and budgets
- Incorporating bias reduction solutions within ongoing AYSRH programs in the country
- Incorporating bias reduction approaches within national AYSRH pre-service and in-service training curricula for facility-based and community-based health workers; Integrating bias reduction interventions within ongoing health system strengthening activities to enhance complementarity of solutions (for example implementing facility infrastructure upgrades that can also support improved client privacy; strengthening contraceptive commodity supply chain systems to ensure comprehensive FP counseling is matched with full method mix availability)
- Advocating for adoption of bias reduction programming targeting private sector providers
- Incorporating bias reduction messaging within complementary, community-based demand generation interventions
- Adopting bias reduction-related indicators within national health information systems and supporting routine monitoring and reporting
- Exploring ways to apply Beyond Bias concepts and behavior change methods to other health areas and/or other client groups where provider bias may be a problem (e.g., reducing bias against other marginalized groups in addition to youth; integrating bias reduction solutions within stigma reduction programming)



PRO TIP

Even if implementation of the Beyond Bias model as described in this guide is not yet within reach, the important thing is to get started addressing provider bias today.

Evidence of Improved Outcomes: How Participants Changed Post-Intervention

Providers in Burkina Faso, Pakistan, and Tanzania were monitored throughout Beyond Bias implementation to ascertain whether and how their views and behaviors might have changed post-intervention.

Beyond Bias evaluation data suggests that positive outcomes were achieved among providers. For example, method restriction based on age, marital status, and parity was reduced by 23, 6, and 15 percentage points, respectively. Other examples of shifts in attitudes and behaviors are included below.



I am not a mother yet but whenever a young client comes to the facility, I can't help but wear a motherly hat and thus fail to give the service. My commitment starts from today to wear one hat at a time."

"I believe that every young person has the right to use family planning. When I was young and newly married, I had one child immediately and that was an extremely traumatizing experience for me. I think of it now and wish I had received good counseling."

"We the health providers are responsible for youth not accessing contraception. We deny them services."

"When a young girl comes to the facility seeking contraception, saying 'Nurse, I would like to have injection for family planning', I would answer her harshly and say, 'Do you know injection? Just go, I am done with you. That is not a good behavior' and she will leave. But through this training, I will change and provide service to youth."

OUTCOMES:

Improved self-awareness among providers of their biases

Improved emotional connection with youth



SECTION II:

How Do I Implement the Beyond Bias Model?



Overview of the Process: A MAP TO THE HOW-TO GUIDE

The remaining sections of this guide contain detailed instructions for how to plan for, adapt, and implement the Beyond Bias approach in your setting.

The length of the preparatory phase (including Steps 1 and 2 below) will vary from setting to setting depending on factors including local resource availability and staff capacity and training needs. Steps 3-5 were designed to take approximately 12 months to complete for the purposes of testing this model, but Steps 4 and 5 can be extended for as long as your budget and timeline allow. From Step 3, ongoing provider follow-up, support, and monitoring activities should ensue, to facilitate sustained provider behavior change.



Conducting a Situational and Segmentation Analysis



Strengthening the Capacity of the Resource Team



Implementing Summit



Implementing Connect



Implementing Rewards



Performance Monitoring, Evaluation, and Learning



Before Diving In: KEY LESSONS WE'VE LEARNED ABOUT EFFECTIVELY ADDRESSING PROVIDER BIAS

OUR TOP 5 “DO’S”

As you begin your own Beyond Bias journey, here are five recommended “do’s” to keep in mind:

NAME BIAS BUT DON'T SHAME BIAS.

Create environments and conditions where providers feel supported and safe from blame or fear of punishment in admitting their own biases.

ACKNOWLEDGE CONSTRAINTS;

ACTIVATE AGENCY. Help providers focus on feasible actions they can take to address biases in their facilities, such as improving the way they listen and speak to a young person and ensuring they provide comprehensive, medically accurate information about the full range of available contraceptive methods.

REWARD GROWTH OVER GOOD.

Recognition for good work is a powerful motivator to change behavior. Reward providers' progress toward standards of unbiased care (see the Six Principles on p. 13) rather than their ranked performance alone.

CONNECT BIAS TO WHAT

PROVIDERS CARE ABOUT. Tackling their own biases is not usually a priority for providers. For providers to be willing to engage, they need to see the value of changing their attitudes and behaviors. Show public sector providers that they will be recognized and valued by their team, supervisor, and the Ministry of Health for providing high-quality care. Give private sector providers integrated advice on business sustainability and customer retention.

CELEBRATE PROVIDERS'

KNOWLEDGE, EXPERIENCE, AND

COMMITMENT. Providers are Beyond Bias' experts and collaborators. They can support their peers to improve service and support a bright future for youth.



STEP

1

Conducting a Situational and Segmentation Analysis

Conducting a situational analysis at the start of the Beyond Bias process will enable your team to understand factors relevant to your implementation context and use this understanding to adapt the model accordingly.

Our process included extensive research that included a literature review, expert interviews, and a provider survey to identify primary behavioral and attitudinal drivers of provider bias across the three countries. The survey data was then used to create a segmentation of providers.

We hope that all of this research and analysis can help serve as a foundation you can build on and save on your resources. It is however critical to consider how this work should be adapted to be contextually relevant for different geographies. Use the segmentation adaptation pathway (**FIGURE 5**) to guide your decisions on how to adapt Beyond Bias implementation tools and materials to your context.

WHAT IS SEGMENTATION?

Segmentation is one tool to help further understand “who your providers are” and how they are likely to behave during family planning-related clinical interactions with adolescent clients. It is important to keep in mind that not all providers are the same – the way that they interact with clients will depend upon their attitudes and beliefs, and the way that bias can manifest in their interactions will likely vary. Understanding the different types of providers in your particular setting will help you adapt your approach to be more effective in reaching them with messages and approaches that will resonate.

Segmentation can be done based on many different factors. For example, focusing on older versus younger providers, or nurses versus mid-wives. Segmentation based on demographic characteristics can be very useful and easy to implement, however, it might fall short when trying to address providers’ deeply held beliefs and behaviors when it comes to addressing biases.

Psycho-behavioral segmentation is another version of segmentation that divides people into groups based on what they do (their behaviors) and why they behave the way they do (the motivations, beliefs, and other factors that influence behavior). By understanding how providers differ based on their underlying beliefs and motivations, it’s possible to better tailor messages and approaches that can address these barriers to more positive behavior change.



WHY DOES THIS STEP MATTER?

Customizing Beyond Bias materials, research and analysis to your country’s specific context is a critical, “must do” step in the process. Segmentation analysis findings can help inform how the team tailors Beyond Bias activities to resonate most effectively with providers. Without this step, your team will lack the evidence base on which to adapt generic Beyond Bias tools and materials to fit your particular population. Ultimately, the greatest utility of segmentation analysis is to inform program design, including decisions about whom to target and how.

LESSONS FROM THE FIELD: WHAT DID WE UNCOVER WITH OUR SEGMENTATION APPROACH AND HOW CAN IT BE USED?

In designing the overall Beyond Bias model, the team underwent an extensive research and development process that included a literature review, expert interviews, and a provider survey to identify primary behavioral and attitudinal drivers of provider bias across the three countries. Through this process, the Beyond Bias team identified the six provider profiles:

1. **Detached professionals:** Well-trained and generally unbiased, though emotionally disconnected with youth
2. **Average passives:** Aware of AYSRH practices, but somewhat biased and relatively unsympathetic for youth
3. **Content conservatives:** Generally open-minded and youth-friendly, but distrustful of modern methods and independent women
4. **Impromptu sisters:** Most connected with young clients, though also prone to believe they know what is best

5. **Sympathetic guardians:** Well-intentioned, and though somewhat misinformed, exhibit overall quality youth service

6. **Paternalistic clinicians:** Busy older doctors who, despite some progressive attitudes, show strong marital and parity bias listed earlier.

Insights arising from the project's large-scale segmentation analysis activities eventually led the team to develop a simplified, rapid psycho-behavioral segmentation tool (see **BOX 1**) that we now recommend you use to identify relevant provider profiles in your setting. Use of this simplified rapid tool eliminates the need to replicate the extensive, resource-intensive segmentation analysis originally undertaken by the Beyond Bias project team. However, in cases where additional research and analysis is deemed necessary, consider the options provided on the Beyond Bias segmentation adaption pathway (see **FIGURE 5**).

FIGURE 5. Beyond Bias segmentation adaptation pathway





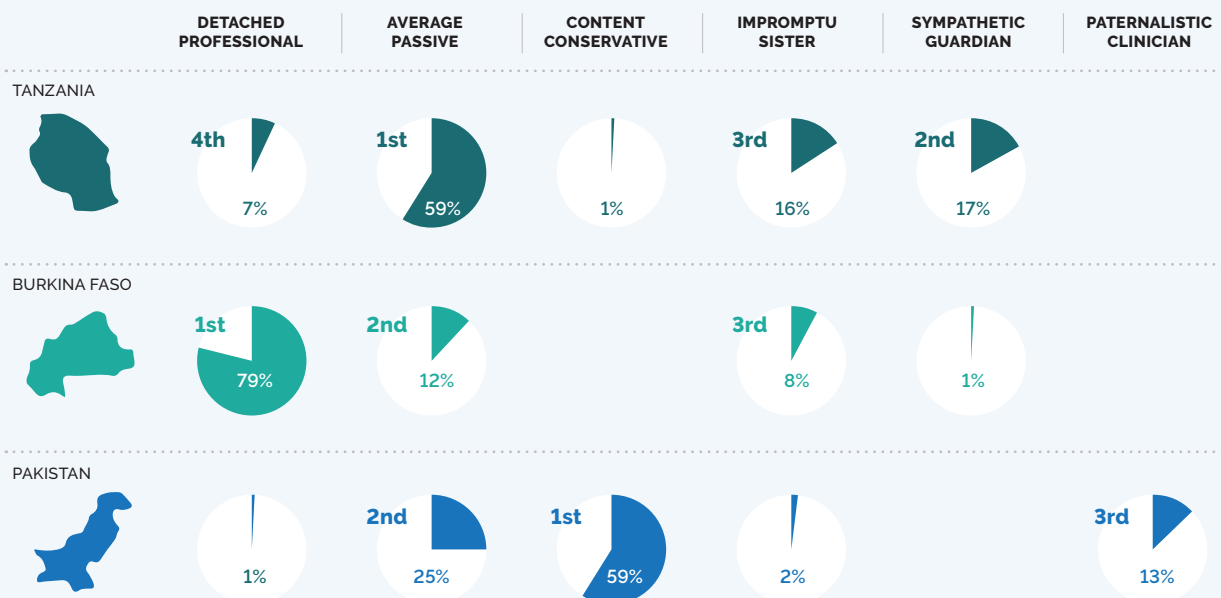
WHY DO PROVIDER PROFILES MATTER?

Provider profiles help you better understand “who your providers are” and how they are likely to behave during family planning-related clinical interactions with adolescent clients. Knowing an individual provider’s profile can lead to interesting insights but even more valuable is identifying which profiles are more or less prevalent within the particular population with whom you are working.

For example, in the Beyond Bias project, the relative composition of provider profile types within the three Beyond Bias countries varied significantly, as shown in **FIGURE 6**. Understanding this, and knowing which profile types were more and less common, allowed each country team to accurately contextualize and tailor their interventions. This, in turn, led each team to better results.

FIGURE 6. Provider Profiles

The Beyond Bias team found that different provider profiles were more or less common among health providers in Tanzania (top row), Burkina Faso (middle row), and Pakistan (bottom row). For example, the “average passives” were the most common type in Tanzania whereas the “detached professionals” were the predominant type in Burkina Faso.



BOX 1. Psycho-Behavioral Segmentation Tool

Here we present the simplified, country-specific psycho-behavioral segmentation tool used by the Tanzania team (for the specific tools used by the Pakistan and Burkina Faso teams, see **ANNEX 1**). For your team, use the segmentation tool from the country that most closely resembles your setting to categorize your provider population. Based on segmentation results, you will then tailor messages and materials to resonate with your common provider types.

Note that if screening with the simplified tool indicates that your provider segments are not accounted for (i.e., a number of providers do not fit any/most of the profiles), you should consider going back and conducting a full, extensive segmentation analysis, rather than relying on use of the simplified tool.

Beyond Bias Classification Tool Example: Tanzania	
Q#	Questions in Section 1
	<p>I'd like to ask your opinion on a few things. I'm going to read you some opinions that people have, and ask for your opinion too.</p> <p>This isn't a test, there are no right or wrong answers. As a reminder, when I say youth or young person, I mean someone aged 15-24, unmarried or married, which is how WHO defines this term.</p> <p>There are five ways that you can respond: strongly disagree, disagree, neutral, agree, or strongly agree. Please choose one response for each statement that shows your opinion.</p>
Q1	<p>CERTAIN FP METHODS ARE NOT APPROPRIATE FOR RELIGIOUS CLIENTS</p> <p>01. Strongly agree [continue] 02. Agree [continue] 03. Neutral [continue] 04. Disagree [continue] 05. Strongly disagree [skip to Q8]</p>
Q2	<p>UNMARRIED YOUTH CLIENTS REQUIRE CONSENT FROM THEIR PARENTS BEFORE CONTRACEPTIVES ARE PROVIDED.</p> <p>01. Strongly agree [continue] 02. Agree [continue] 03. Neutral [continue] 04. Disagree [continue] 05. Strongly disagree [skip to Q6]</p>
Q3	<p>IUDS ARE APPROPRIATE FOR YOUNG WOMEN WITHOUT CHILDREN</p> <p>01. Strongly agree [end = Average Passive] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [continue]</p>
Q4	<p>I PREFER NOT TO PROVIDE AN FP METHOD TO A CLIENT IF THEY WILL NOT TAKE AN HIV TEST</p> <p>01. Strongly agree [end = Average Passive] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [continue]</p>

Q#	Questions in Section 1 (cont.)
Q5	<p>AT TIMES IT CAN BE EMBARRASSING FOR ME TO DISCUSS SEX WITH YOUNGER CLIENTS.</p> <p>01. Strongly agree [end = Average Passive] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [end = Impromptu Sister]</p>
Q6	<p>I ENJOY WORKING WITH YOUNG CLIENTS IN GENERAL/NINAFURAHIA KUFANYAKAZI NA WATEJA VIJANA</p> <p>01. Strongly agree [continue] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [end = Average Passive]</p>
Q7	<p>YOUNG WOMEN WITHOUT CHILDREN SHOULD NOT USE ANY PRODUCT THAT MIGHT CAUSE A DELAY IN FERTILITY ONCE STOPPED</p> <p>01. Strongly agree [end = Impromptu Sister] 02. Agree [end = Impromptu Sister] 03. Neutral [end = Impromptu Sister] 04. Disagree [end = Impromptu Sister] 05. Strongly disagree [end = Sympathetic Guardian]</p>
Q8	<p>A CLIENT WITH JUST ONE DAUGHTER WILL HAVE DIFFERENT FP NEEDS THAN A CLIENT WITH JUST ONE SON.</p> <p>01. Strongly agree [end = Average Passive] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [continue]</p>
Q9	<p>OTHERS HAVE EXPRESSED THEIR DISAPPROVAL TO ME ABOUT THE CONSULTATIONS I PROVIDE TO YOUNG GIRLS ABOUT FP</p> <p>01. Strongly agree [continue] 02. Agree [continue] 03. Neutral [continue] 04. Disagree [continue] 05. Strongly disagree [end = Sympathetic Guardian]</p>
Q10	<p>PROVIDING CONTRACEPTIVES FOR UNMARRIED YOUNG PEOPLE MAY MAKE THEM MORE PROMISCUOUS.</p> <p>01. Strongly agree [end = Impromptu Sister] 02. Agree [end = Impromptu Sister] 03. Neutral [end = Impromptu Sister] 04. Disagree [end = Impromptu Sister] 05. Strongly disagree [end = Sympathetic Guardian]</p>

Steps in Conducting a Situational and Segmentation Analysis

1

Conduct a local policy analysis to identify key priorities for contraceptive access for youth.

2

Assess the landscape of public and private sector FP/SRH service delivery to understand potential facilitators and barriers to Beyond Bias implementation. Include within the analysis an examination of:

- Existing AYSRH training programs
- Level of youth friendliness of services
- Quality of AYSRH care benchmarks currently in use
- Data collection methods in use, including youth indicators

3

Conduct audience and communication analysis to better understand who and what influences FP/SRH practices in the community and country by interviewing experts and stakeholders including:

- FP/SRH policy leads from the Ministry of Health (MOH) Policy stakeholders such as provincial/ regional and district health managers
- Youth/adolescents, both married and unmarried
- Representatives from health care professional associations
- Key community gatekeepers such as religious/civil society leaders and parents of adolescents

4

Select the appropriate simplified psycho-behavioral segmentation tool from the three examples provided and use it to profile your providers [OR conduct additional analysis if needed].

5

Based on results from Step 4, tailor Summit, Connect, and Rewards messaging using the table on the next page as your guide.



PRO TIP

Engaging key stakeholders during program planning and implementation is critical for short-term impact and long-term scale and sustainability. As you think about how you might scale the Beyond Bias intervention, discuss the following with your team:

With which key stakeholders do you already have relationships? With whom do you need to develop relationships?

What outcomes do stakeholders need to see in order to consider the approach effective and credible?

During the implementation period, how can you create opportunities for stakeholders to directly observe the value and impact of the approach?

Where can you build opportunities for stakeholders to contribute to the program?



Tailoring messaging for each provider profile type

Profile type:	Will likely be/have:	Reach these providers by tailoring messages in this way:
DETACHED PROFESSIONALS	<p>Relatively low attitudinal bias and generally low behavioral bias</p> <p>Lack empathy, seem not to care deeply, drawn to low-risk approaches (e.g., supporting abstinence over FP methods)</p> <p>Behavior change among this group may be relatively straightforward</p>	<p>Focus on emotional connectivity rather than clinical education</p> <p>Appeal to their professionalism and concern over clinic reputation</p>
AVERAGE PASSIVES	<p>Higher degree of attitudinal and behavioral bias compared to Detached Professionals</p> <p>Lack a solid educational base (either due to lack of personal FP use, lack of training, or inexperience serving youth clients) and may not have proper protocols embedded as part of their routine</p> <p>Feel strongly it's not their role to teach youth how to behave</p>	<p>Build empathy and help providers connect with youth clients through use of compelling youth narratives</p> <p>Address educational shortfalls</p>
CONTENT CONSERVATIVES	<p>Severe behavioral bias though not as extreme as Paternalistic Clinicians</p> <p>Typically well-trained</p> <p>Enjoy their jobs and working with youth</p> <p>Believe they are responsible for teaching youth how to behave</p>	<p>Address FP method misinformation and formalize delivery protocols</p> <p>Be mindful of strong cultural norms in settings where these providers operate</p>
IMPROMPTU SISTERS	<p>Exhibit less bias than other segments though strongly identify/connect with youth clients which can lead to judgmental behavior</p> <p>Have a desire to protect fertility</p> <p>If behaviors among this group are engrained, behavior change can prove to be difficult</p>	<p>Educate on method safety, value for youth</p> <p>Leverage their prior personal use of family planning methods</p> <p>Appeal to their natural inclination to be "big sisters" who, though hard on their younger clients, are also able to empathize with them</p>
SYMPATHETIC GUARDIANS	<p>Lowest levels of bias of all profile types</p> <p>May be "a little out of touch" with youth but are very well-intentioned</p>	<p>Focus on the value to youth of birth spacing and limiting</p> <p>Clarify safety and value of LARCs (e.g., IUDs)</p>
PATERNALISTIC CLINICIANS	<p>Highest/most severe level of bias</p> <p>Set in their ways and difficult to modify behaviors</p> <p>Prone to denying FP counseling and services to the young, unmarried, and/or nulliparous</p>	<p>Emphasize efficiency through tools to aide AYSRH counseling, given the overbooked nature of this segment</p>



PRO TIP

It is important to recognize that the above guidance should be supplemented with additional information gathered by your team. Setting-specific information will enhance what is known about your target population and will help you more effectively tailor your interventions.

LESSONS FROM THE FIELD: WHAT TO DO WHEN A SEGMENT IS TOO LARGE?

Very large segments (60%+ of a given sample) can pose a challenge because given their size are less likely to be homogenous compared to smaller and more 'niche' segments. This is more likely to occur when segmenting across multiple countries - in our case, Detached Professionals accounted for 79% of Burkina Faso providers, and they clustered together as they were more similar in profile to one another than they were to providers from other countries. When implementing Beyond Bias tools in Burkina Faso, it may be helpful to refer to the qualitative research to identify additional nuance that can be helpful in addressing this segment or select one defining attribute or belief from the quantitative research to further break this segment apart (e.g., Detached Professionals who strongly promote abstinence vs. those who do not, or those who feel overloaded vs. those who do not).



STEP 2

Strengthening the Capacity of the Resource Team

Many people will be involved in making your Beyond Bias effort a success.

This section describes the key people needed for program implementation, phases during which each person is needed, each person's main responsibilities, and training needed to enable team members to implement the program effectively.

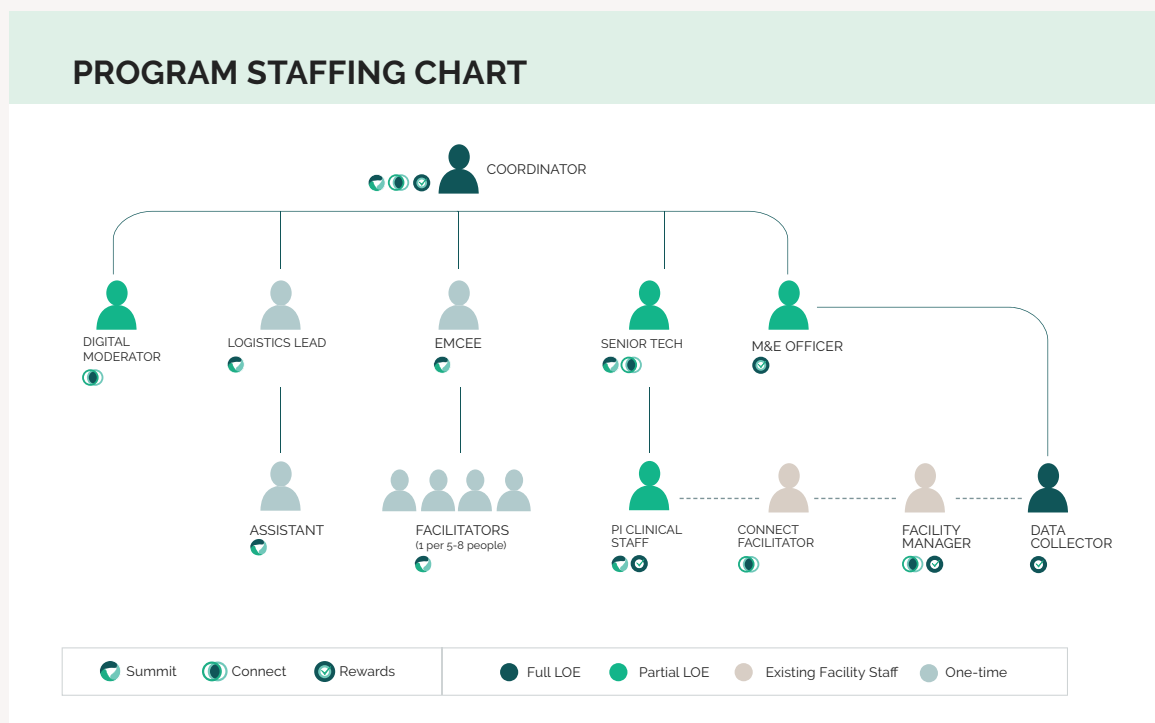
FIGURE 7 gives an overview of key members of the team, relationships between team members, and the level of effort needed for each role. Also indicated are the specific program phases during which each member is required. On the following page, we outline the core responsibilities associated with each role.



WHY DOES THIS STEP MATTER?

Engaging, coordinating, and training team members is critical to the success of your program. The more organized and prepared team members are, the more confident and credible they will be. This will help them build trust with participating providers.

FIGURE 7. Recommended program staffing chart



Role	Phase	Responsibilities
BEYOND BIAS COORDINATOR	All	<p>Coordinate work planning and resourcing for Beyond Bias implementation period Supervise data enumerators</p> <p>Oversee data collection for implementation monitoring and evaluation</p> <p>Lead preparation and execution of Summit events</p> <p>Train Summit facilitators for successful activity execution</p> <p>Train Connect facilitators to lead facility-based activities</p> <p>Provide supportive mentorship to Connect facilitators on curriculum progress Organize and lead the Q1, Q2, and Q3 Rewards events</p> <p>Coordinate with M&E officer on data analysis and visualization</p> <p>Deliver training and refresher skills building to facility managers and Connect facilitators</p> <p>Coordinate engagement of key stakeholders across a 12-month implementation period</p>
SENIOR TECHNICAL ADVISOR	Summit, Connect	<p>Deliver key content at Summit ("What is Bias?" section) and answer technical questions that arise Answer technical questions and method myths that arise during Connect</p> <p>Support Beyond Bias coordinator on technical and policy matters</p>
MONITORING AND EVALUATION (M&E) OFFICER	Rewards	<p>Support data collection for implementation and M&E</p> <p>Coordinate with M&E officer and data team on data analysis and visualization for report cards</p> <p>Manage performance monitoring and ensure consistent data collection by enumerators</p>
CLINICAL STAFF	Summit, Rewards	<p>Support key implementation activities, such as Summit preparation and facilitation, data collection, and Rewards events</p>
EMCEE	Summit	<p>Orchestrate and lead Summit activities</p> <p>Qualifications: Must be well-versed in objectives, structure, content, and agenda to guide participants through the day's activities; must be energetic and engaging with participants</p>
SUMMIT FACILITATORS	Summit	<p>Guide group activities and fosters positive engagement in exercises</p> <p>Manage time, activities, and attendee contributions in line with content Qualifications: Previous experience with facilitation is preferred but not required</p>
LOGISTICS LEAD	Summit	<p>Oversee pre-planning and day-of Summit logistics</p> <p>Lead coordination with venue partner</p> <p>Manage budget and has authorization to release payments</p> <p>Ensure event unfolds in an orderly and timely manner within expectations and budget Qualifications: Able to maintain calm in organizing all steps and both regularly and clearly communicate logistics plan with key team members</p>

CONTINUED

Role	Phase	Responsibilities
LOGISTICS ASSISTANT	Summit	<p>Manage registration and sign-in process and ensure all participants are registered</p> <p>Ensure attendees receive name tags, participant materials, and consent forms</p> <p>Ensure full set-up is complete at minimum 1 hour prior to start of event</p> <p>Provide general support to ensure logistics run smoothly</p> <p>Ensure all materials are prepared and consolidated, and manage audio-visual materials</p> <p>Qualifications: Proactive problem solver, strong interpersonal skills. Able to carry medium-weight supplies and equipment (e.g., chairs, tables, speakers). Comfort with computers and technology preferred</p>
CONNECT FACILITATORS (EXISTING FACILITY STAFF)	Connect	<p>Organize, convene, and lead Connect sessions with facility providers</p> <p>Foster peer-exchange and learning through interactive engagement with facility providers</p> <p>Lead structured review of Rewards report and progress with providers following quarterly evaluation Develop and deliver locally-adapted content during Connect maintenance phase (months 4-12) Qualifications: Must have obtained some level of respected authority within facility system (e.g., head nurse, chief of maternity)</p>
DIGITAL MODERATOR	Connect	<p>Moderate the conversation among providers on digital WhatsApp Connect forum</p> <p>Respond in timely manner to provider questions</p> <p>Engage technical experts as needed to answer provider questions</p> <p>Proactively adapt content as needed to sustain and improve provider engagement</p> <p>Track engagement data</p> <p>Qualifications: Strong familiarity with Connect digital moderator guide. Able to respond to participants in kind, diplomatic, and supportive manner. Comfort with smartphones and WhatsApp. Basic technical knowledge of contraceptive methods</p>
FACILITY MANAGERS	Connect, Rewards	<p>Oversee day-to-day facility operations</p> <p>Create an enabling environment within the facility for providers to engage in Connect</p> <p>Ensure active participation of facility providers in Connect sessions</p> <p>Supervise and provide coaching to unit staff for applied practice of learnings from Connect Attend and participate in quarterly performance review</p> <p>Actively engage in knowledge sharing and cross-facility learnings during quarterly review</p> <p>Coordinate with Connect digital moderators to deliver Rewards ceremony at facility Qualifications: Part of facility management staff hierarchy. Able and willing to participate in Beyond Bias program</p>
ENUMERATORS	Rewards	<p>Ensure routine data collection at facilities based on agreed-upon schedule Administer client survey tool and collect routine facility data</p> <p>Coordinate with M&E officer for data analysis on a monthly and quarterly basis</p>

As soon as the resource team is in place, begin strengthening the team's capacity to effectively implement the program by training them to be able to do the following:

1

Understand and recognize provider bias and why it is important to address it.

2

Articulate the difference between misconceptions, myths, and biases.

3

Implement the three components of the Beyond Bias approach (Summit, Connect, Rewards) using the standard agenda, exercises, and tools included in this guide.

4

In addition to training core staff (Beyond Bias Coordinator, Senior Technical Officer, and M&E Officer), other members of the resource team must be trained to fulfill their specific project duties. Specifically:

- **Two weeks before the Beyond Bias launch, data enumerators must be trained to have a clear understanding of data collection goals and protocols; be able to administer surveys with clients at facilities; and be able to use and troubleshoot the data collection tool and tablet.**
- **Quarterly supervision of data enumerators will help ensure that they understand and can lead facility-based data collection in a way that ensures accuracy and verification throughout the program.**
- **Quarterly mentorship of facility managers is also important to strengthen their ability to supervise providers, review progress toward providers' performance in delivering unbiased care, and recognize and celebrate successful provider teams.**



STEP

3

Implementing Summit

Summit is the foundation of Beyond Bias.

It is a one-day, in-person event that **activates** providers' motivation to actively examine and eliminate their own biases. A facilitated series of small-group discussion and reflection activities introduce providers to the program and the Six Principles framework. The following activities comprise the core ingredients for Summit success:

- Youth and providers share personal, emotional stories. Respected authority figures give professional permission to serve youth.
- Providers learn to own their biases through guided reflection activities.
- Providers make individual action plans and public commitments.

Summit Objectives:

- To improve providers' ability to emotionally connect with youth
- To support providers to develop awareness of their own biases
- To prepare and motivate providers to participate in Beyond Bias with their peers



WHY DOES THIS STEP MATTER?

Summit is the first of the three Beyond Bias pillars. During this event, providers come together and start developing awareness of their own bias. This is an important first step toward learning how to apply unbiased practices in their own work and becoming advocates for improved contraceptive services for youth in their community.



ABOUT SUMMIT:

Summit is a story-driven, in-person event that activates providers' self-awareness of their own biases and their empathy for young people's needs. Summit lasts 4 to 6 hours and engages up to 40 providers per event. Each event includes testimonials and interactive group exercises and content is proportionally tailored to the provider segments in that country (e.g., including a story of a young woman to whom a provider advised abstinence in Burkina Faso versus including the story of a young woman who was only offered condoms in Tanzania).



Ingredients for a Successful Summit:

A manageable group size: We recommend a maximum of 40 participants per event. The number of participants per event and number of Summit events you need to organize will depend on the number of participating facilities, the number of available facilitators (Summit requires one facilitator for every eight participants to ensure engaging, interactive small-group discussions), and venue size.

A central location: Summit should be hosted at a central location that providers from a given cohort of facilities can easily reach. The venue must have audio-video capabilities and space for enough tables to hold small groups of six to eight participants. Appropriate timing: Summit should take place within the first four weeks of the launch of the program. Each provider will attend one Summit. Participating facilities are divided into cohorts, based primarily on geographic proximity and client volume. To enable multi-provider facilities to continue normal operations during Summit, at least two Summit events should be held per cohort.

Trained staff: At minimum, each Summit will need:

- Beyond Bias coordinator to lead event coordination and preparation;
- Event emcee to guide event and activity transitions (this role may be played by the coordinator);
- Senior technical expert to deliver key content during the event;
- Facilitators to lead small-group discussions with providers;
- Logistics coordinator and logistics assistant to support event materials preparation and logistics throughout the day.

Compelling guest speaker(s): This should be a respected technical or policy expert who will make opening remarks. This high-level local stakeholder/advocate/influencer should be a compelling speaker, should be well-aligned with national priorities, and should be seen as someone who is contributing to an enabling policy environment for AYSRH. For example, Beyond Bias invited respected

public sector leaders to speak in Tanzania and Burkina Faso and a senior OB/GYN to speak in Pakistan. The guest speaker should be able to help address myths and build agency among providers to take the next step in their behavior change journey.

Youth and provider storytellers: The most powerful youth/provider stories are authentic and emotionally compelling. Stories should be recorded (we recommend video recordings) in a way that makes the storyteller comfortable and able to be honest about their experiences, without fear of judgement. See **ANNEX 3** for a guide for recording Summit video stories.

Attendees: All FP/SRH service providers (nurses, midwives, assistant midwives) in participating facilities, divided into cohorts of facility managers and lead nurses, if possible.

LESSONS FROM THE FIELD

The success of a Summit event is best assessed by the extent to which providers are able to reflect on and own their biases. When Summits were held in Burkina Faso, Pakistan, and Tanzania, facilitators found that different methods were required from setting to setting to help participants open up to reflection and sharing activities. For example, while Tanzanian providers spoke openly about their experiences and struggles in the presence of their colleagues and project staff, providers in Pakistan were more reserved, prompting the team to devise "reflection circles" in which providers sat in discussion circles with their backs facing each other. This arrangement, in which participants could share stories more anonymously, made them more comfortable about talking about their own biases and experiences with bias. Meanwhile, in Burkina Faso, written anonymous personal accounts were used as a sharing device, as providers there were not comfortable discussing their biased behaviors openly.





Preparing compelling youth stories —

the project team found that showing pre-recorded videos of adolescents telling their family planning-related stories was a highly effective way to start conversations during Summit events. During the Beyond Bias project, providers in the three countries reported feeling connected to adolescents featured in the videos and, once emotionally drawn in, often responded by sharing their own personal experiences and stories with other Summit attendees. The videos were an excellent launching point for subsequent Summit discussions because they made the subject “come alive” for participants and prompted them to reflect on their own behaviors.

To make high-quality videos, Beyond Bias country teams worked with local organizations skilled in video development and production. Key steps in the process of making quality videos included sketching out a loose “script” identifying major topics and themes to be discussed; identifying a local adolescent willing to (and providing written consent to) share her story; holding rehearsals to build the adolescents’ comfort level with the material and production; and, after filming, editing raw footage into a 5-7 minute final product.

Through trial and error, the team found that the most effective videos were those that featured true (non-fictional) stories of adolescents’ interaction

with FP providers, highlighting their experience of bias and the immediate and long-term negative consequences of the bias they faced. Compelling stories should speak to the real environments in which Summit participants and adolescents live. The tone should be personal and able to bring out empathy and foster connection between youth and providers.



Engaging key stakeholders in Summit can

facilitate program sustainability and scale-up. Invite a national-level MOH representative to be the Summit guest speaker (see **ANNEX 3** for sample talking points for keynote/guest speakers) and/or invite district MOH officials to attend Summit. Guest speakers should link the importance of serving young people with existing national health strategies. If working with private sector providers, invite a relevant high-level medical professional to be the Summit guest speaker.



Invite providers who are youth champions

(positive deviants) to serve as Summit facilitators to lead small group activities.



Focus on the Six Principles of Unbiased Care

Cards and Action Planning cards (see example cards in **ANNEX 3**).

Preparing for and Implementing Summit

Leading up to a Summit event, the Beyond Bias coordinator, facilitation team, and logistics coordinator will engage in preparations detailed in the timeline below. In addition to logistical preparations, Summit facilitators must be trained to understand Summit objectives, structure, and activities and to be able to guide participants through small-group activities. Summit assistants must be trained to become familiar with the event agenda, activity materials, logistics, and supplies, and to be able to provide audio-visual and other technical support during the event.

4-8 WEEKS IN ADVANCE	<ul style="list-style-type: none"> • Develop your customized Summit Facilitation Guide (based on the sample Facilitation Guide noted in ANNEX 7) to guide the Summit event and plan for other preparatory activities. An example Summit agenda and goals for the event are shown in BOX 2. • Finalize the list of facilities and providers who will be invited to attend. Recruit a respected keynote/ guest speaker to provide remarks in person or via video at the event.
3 WEEKS IN ADVANCE	<ul style="list-style-type: none"> • If the guest speaker will appear via a pre-recorded video, record a 5-7 minute video with high-quality sound to be shown at the Summit event. Book the Summit venue and catering. The venue should have enough space for small-group activities. • Meet with health facility managers to orient them to the program and prepare them for launch.
2 WEEKS IN ADVANCE	<ul style="list-style-type: none"> • Finalize the list of Summit participants and send them invitations. Print all event materials. (See the sample Summit Facilitation Guide noted in ANNEX 7 for a materials checklist.) • Prepare facilitator training agenda and materials. • If the guest speaker will appear in person, meet to review key talking points and logistics.
1 WEEK IN ADVANCE	<ul style="list-style-type: none"> • Hold a Summit training for facilitators and assistants (see ANNEX 2 for sample Summit Facilitator agenda). • Confirm provider participation (within 3 days of Summit).
DAY OF SUMMIT	<ul style="list-style-type: none"> • If not already done, at least one hour before the scheduled start, set up the venue and registration process and arrange tables and activity materials for each table. • Review the day's agenda with the whole team so that everyone is aware of their timing and roles. • During participant registration, provide all attendees with training materials and ensure that all attendees sign a photo consent form. If Connect will be implemented virtually, collect participants' phone numbers now to add them to the WhatsApp group.
DURING THE EVENT	<p>Prepare a context-specific slide deck (presentation) and follow the activities as outlined in the Summit Facilitation Guide.</p> <p>Remind all participants throughout the event that it is a safe space where they can reflect and share openly.</p>
AT THE END OF THE EVENT	<ul style="list-style-type: none"> • Introduce and provide an overview of the coming Connect and Rewards stages. Describe what providers can expect during these stages. Share the timeline for the launch of Connect. • Where Connect is being implemented virtually, check that all participants are registered on the WhatsApp group. • Distribute the provider survey to gather attendee feedback. • Thank everyone for their time and recognize their participation.
AFTER SUMMIT	<ul style="list-style-type: none"> • Reflect, learn, and use feedback to refine future activities Monitor and analyze data, using results to refine future activities

BOX 2. Sample Summit Agenda and Goals

When the Pakistan Beyond Bias team held a Summit event, this was how they designed the event agenda:

AGENDA	
2:00 PM	Welcome • Introductions
2:20 PM	Keynote speaker
2:40 PM	Stories, Discussion, and Reflection
3:15 PM	Why focus on younger clients? A business perspective.
4:00 PM	Break
4:15 PM	Overview of the Beyond Bias program
5:00 PM	6 Principles of Quality Care
5:15 PM	Next steps
5:30 PM	Feedback • Closing Discussion
6:00 PM	Close

And these were the goals for the Summit, as they were described to Summit participants:

OUR GOALS TODAY		
1. Discuss the social benefit and business opportunity of expanding family planning access for younger clients (15-24 years).	2. Reflect on how we can take action to improve quality of reproductive healthcare for our younger clients.	3. Reflect on how we can take action to improve quality of reproductive healthcare for our younger clients.



PRO TIP

In Pakistan, Beyond Bias providers came from the private sector, not the public sector. This explains why (as shown in the above examples), the team customized its approach and materials to resonate with private sector providers' specific interests and concerns. The team incorporated business perspectives and highlighted the social and business-related benefits of delivering unbiased AYSRH care.

When implementing Beyond Bias in your setting, remember to always customize the approach, messaging, and materials for your specific audience.

MATERIALS NEEDED TO IMPLEMENT SUMMIT

To implement Summit effectively, an assortment of materials will be needed at different times by different people. The table below lists specific items needed and quantities of each. Examples of some of these materials are shown below the table and additional examples can be found in **ANNEX 3**. Remember that all materials must be customized for your specific country setting and audience.

TECHNOLOGY SUPPLIES AND DIGITAL ASSETS:

- Microphone (1-2)
- Laptop (for presentations) Projector (1)
- Youth video story Provider video story (if applicable)
- Guest speaker video speech (if applicable) Camera for event documentation

ACTIVITY SUPPLIES:

- Markers (1 per table)
- Flip charts (1 per table) Tape (1 per table)
- White paper (1 per participant)
- Post-It notes (10 pads per table)
- Six Principles cards (1 per table)

FOR ORGANIZERS:

- Program staffing chart
- Implementation materials checklist
- Summit agenda Attendance sheet with photo consent form Guide for Recording Summit Video Stories Summit event printed materials
- Talking points for keynote speaker
- Program banner for venue Cards with table numbers Timer

FOR FACILITATORS:

- Summit Facilitation Guide (1 per facilitator)
- Summit facilitator agenda (1 per facilitator)
- Summit slide deck and emcee speaker notes
- Reflection activities materials (see Summit Facilitation Guide for complete checklist)

FOR PROVIDERS (PARTICIPANTS):

- Notebook with program sticker
- Pens (1 per participant) Participant agenda (1 per participant)
- Action planning cards (1 per participant) Commitment pins (1 per participant)
- Name tags (1 per participant)
- Print copies of youth and provider stories (1 set per participant)

MATERIALS KIT FOR HEALTH FACILITIES:


- Inspiration poster (1)
- Six Principles poster (2)
- "Do not disturb" sign (2)

Examples from Beyond Bias in Burkina Faso:

NAME: _____ FACILITY: _____

What are two ways that bias can show up when you are counseling a youth client on contraceptive methods?

What are two actions that you will take to address these biases in your own practice?



Action planning card
(1 per provider)



Commitment pins
(1 per provider)



Name tags
(1 per provider)

More Tips For Summit Success: Lessons We've Learned

DO focus first on problematizing bias. Not all providers see behaviors like denying service to youth as a problem in the first place. Before asking providers to change their behavior, focus on helping them understand how it can have negative consequences. Encourage values-focused discussions among the participants.

DO show real data that illustrates that bias is happening in facilities like the ones where participants work. Providers may say that bias is something that happened in the past or that they do not treat youth clients poorly like other providers do. Use data to show participants that bias is affecting services in their area and they cannot ignore biased attitudes and behavior.

DO have a respected person discuss his/her own struggles with bias so that providers feel safe to do so as well. This is a critical ingredient that helps humanize the problem and supports providers in sharing ownership of problems and solutions. If possible, invite guest speakers to speak in person rather than via video. Permission given to serve youth from a respected senior medical professional is an important part of Summit. In-person interactions can humanize authority figures and help them communicate more effectively.

DO focus on tactical problem-solving. Acknowledge providers' constraints and support them to identify feasible actions they can take. Many factors in addition to bias can make it difficult for a provider to offer high-quality services to youth clients, including but not limited to stock-outs, staff shortages, and lack of space. Be realistic about positive changes participants can make and help them develop actions they can take to effect changes. Give specific examples of how to apply the Six Principles and invite participants to share their ideas and tips.

DO help participants focus on things they CAN control, such as how they listen and speak to a young person and what method-related information they provide.

DO create anonymous space(s) for providers to admit their own biased behavior. Providers who work in large health facilities are part of a hierarchical system. Providing them space to share

their stories of bias without fear of being punished in their work setting is critical.

DO use positive deviants' stories to inspire action. It is important for providers to see examples of people like them who are taking action despite challenges and possible social consequences. Find and elevate stories from providers who have changed their attitudes and behaviors toward youth clients. These stories can be delivered in person or via video at Summit.

DO start to dispel key myths. While the focus of Summit is not on technical (clinical) content, make sure to have a respected technical speaker present to dispel common myths. This foundation of "myth dispelling" will be built upon in Connect.

When working with private sector providers, DO make the "business case", in addition to the social case, for why it is important to serve youth. As small business owners, providers are receptive to the business implications of serving (or not serving) youth, a potentially large client base. Note that while this argument is meant to be compelling, it should not be a standalone argument and must be combined with arguments for broader societal health, wellbeing, and prosperity.



AND A FEW "DON'TS"

DON'T shame bias and berate providers for their mistakes. To admit biases and mistakes in front of colleagues, providers must feel that they won't be punished or shamed. Providers should be assured that they can take a risk in talking about their own shortcomings.

DON'T push prescriptive content onto providers without discussion. Support discussion and dialogue instead of one-directional teaching. Providers need time to engage with others' opinions and experiences and come to their own realizations about bias and its impact on youth. Guide reflective conversation in which participants can arrive at their own answers and solutions.

OUTCOME: WHAT SUMMIT WAS LIKE

IN TANZANIA Between 12-20 November 2019, the Beyond Bias team in Tanzania held four Summit events. 152 providers attended Summits, representing 36 public sector facilities. Commented one participant: "This type of workshop, where we started by sharing our personal facts, dance together, exchange experience, is different from others where we are used to sitting and being lectured on, this one makes me feel safe to open up."

Participants were particularly encouraged by hearing public endorsements of support from local authority figures. For example, a Regional Medical Officer

representing Dar es Salaam was invited to be a Summit keynote speaker and said, "You and I know that at that age, we explored, did some worse acts, had sexual partners, only that they went unnoticed and some of us have been lucky enough to have someone to guide us. Let us put us in that shoe, travel back the memory lane, and feel the pinch of not becoming who we are today. This will give us the reason to willingly help. Let us then help them achieve their dreams."



IN PAKISTAN During Pakistan Summits, providers were introduced to the Six Principles of Unbiased Care and received posters, a Six Principles booklet, and other materials. Through a guided exercise and use of "commitment cards", each

provider identified at least one principle to work on moving forward. Summits ended with a commitment pin given to each provider by guest experts in the room.

During the event, many providers confessed that they don't entertain young clients, especially nulliparous clients. Rather than advising youth on FP, they encourage them to have at least 1-2 children before opting for a FP method. A few providers admitted that they don't encourage long-term

methods to youth even if they ask for it. When a video case study of a girl named Naseema was shared, providers connected with Naseema's pain and suffering; some reflected that there must be many such young girls suffering daily due to provider biases.

As one Summit participant shared, "My own daughter got married in March this year and she mentioned she wanted to use family planning to delay first birth. Even though I am a provider, I told her not yet, in case something were to go wrong. She is still studying but went along with my advice. In the following months she got pregnant and now is under a lot of stress and is experiencing many difficulties. I regret this decision of mine and wish I had counseled her as I should have."

IN BURKINA FASO Similar reflections were shared in Burkina Faso, where one participant had this to say about how her views have changed since attending a Summit, "A 16-year-old girl in Form 4 came to the health facility where I was working around 12 o'clock for family planning. With fatigue and hunger, I told her to come back in the evening. Since

then she has not returned to the [health center] and the last time I saw her was during the medical check-up of people three months later with a pregnancy. I really regret t his attitude."



STEP

4

Implementing Connect

Connect is the second part of the Beyond Bias intervention.

Connect supports providers to **apply** the Six Principles in their daily practice with youth clients by dispelling myths and misinformation, sharing AYSRH technical content and case studies, and providing cues to solve challenges they encounter in their work. While Summit provides a platform to identify and understand sources of bias, Connect provides a platform for providers to discuss, contextualize, and exercise agency to serve youth in an unbiased manner. Connect can be delivered in person, digitally, or in a blended format (see **BOX 3**) depending on the context. Whichever the format, core ingredients for success are the same:

- Realistic case studies of youth clients that drive discussion with peers;
- Technical expertise and practical tips that dispel misinformation;
- Safe space to share struggles and successes with peers;
- Regular review of unbiased service delivery goals.

Connect Objectives:

- Dispel misinformation among providers about what contraceptive methods are appropriate and safe for youth.
- Reinforce unbiased counseling practices.
- Support providers to continuously identify practical actions they can take to improve their service delivery to youth, given the realities and constraints of their workplace.
- Shift facilities' professional norms toward serving youth.



WHY DOES THIS STEP MATTER?

During Connect, providers receive ongoing peer support and actively participate in a learning forum where they can problem solve ways to apply unbiased practices in their daily work. Providers are supported through an iterative process of applying new behaviors and, through trial and error (and possible periods of action and relapse), build contextualized agency over time.






ABOUT CONNECT:

Providers begin Connect the week after they attend Summit and are grouped with the same cohort they met during Summit. As described in the following section, Connect consists of two phases — an intensive phase and a continuous learning phase — though the approach is meant to be flexible and thus timing and modalities can be adapted based on your team's needs. The intensive phase as described here is 8-10 weeks long and is completed before the first round of Rewards events. The continuous learning phase begins in month 4, after the first round of Rewards events, and ends in month 12. During the continuous learning phase, providers are engaged once or twice a month, depending on the intervention delivery method.

BOX 3. How Connect is Delivered: Three Formats

Providers begin Connect the week after they attend Summit. Connect is organized in alignment with the same cohort as Summit. Connect has three delivery formats - in person, digital, and blended - and can be adapted to meet the needs of your specific context. For example, in the Beyond Bias project, Connect was delivered in person in Burkina Faso, digitally in Pakistan, and using a blended format in Tanzania based on stated preferences of participants in each country.

	 In-Person	 Digital	 Blended
DESCRIPTION	In multi-provider facilities, Connect is implemented through short, in-person meetings. Each facility conducts its own Connect sessions. Senior clinical staff lead the meetings after receiving a one-time training from the project team.	In single-provider facilities, Connect engages clinicians through digital communication tools, for example use of a WhatsApp group moderated by the project team.	In high-volume, multi-provider facilities, Connect is implemented primarily through short, in-person meetings. Each facility conducts its own Connect sessions. Senior clinical staff lead meetings after receiving a one-time training from the project team, which also moderates provider WhatsApp groups. WhatsApp groups provide light-touch reinforcement of material covered in in-person meetings.
DOSE (INTENSIVE PHASE, MONTHS 1-3, though specifics can be adapted based on need)	Weekly 30- to 40-minute in-person meeting (4 sessions over 8 weeks)	1 module of content and questions delivered via WhatsApp each week for 10 weeks	Weekly 30- to 40-minute in-person meeting (4 sessions over 8 weeks) + 1 digital prompt per week for 8 weeks
DOSE (CONTINUOUS LEARNING PHASE, MONTHS 4-12, though specifics can be adapted based on need)	Monthly in-person meeting over 8 months	2 digital mini-modules per month for 8 months	Monthly in-person meeting + 1 monthly digital prompt for 8 months
WHO ATTENDS	All FP providers	One WhatsApp group per cohort	All FP providers
WHO LEADS (FACILITATOR)	Head nurse	Beyond Bias team and designated stakeholders moderate digital discussion	Unit in-charge



PRO TIP

Engaging stakeholders in Connect to increase potential for provider adoption, sustainability, and scale up: To encourage public sector engagement, invite key MOH representatives to be “guest technical experts” on Connect WhatsApp groups with facility managers. If working with private sector providers, invite key technical experts from other stakeholder organizations to be guest technical experts on Connect WhatsApp groups.

Implementing In-Person and Blended Connect

Regular mentorship is critical in supporting Connect facilitators to deliver locally adapted content; to effectively engage staff in collective learning, action, and exchange; and to use data and performance evaluation to improve quality in daily practice. During the intensive phase of Connect, facility-based Connect facilitators should be mentored weekly. During the continuous phase, the frequency of mentorship check-ins can be reduced to monthly and can occur via the WhatsApp group.

Mentorship includes:

- **Supporting facilitators to prepare for upcoming sessions:** reading through the week's module and case study; sending reminders via the Leaders WhatsApp group on the title, topic, and materials for the week's session.

- **Following up on the week's session:** inviting facilitators to share any questions or sources of confusion that came up in the session that require technical clarification; if needed, engaging a senior technical staff member to answer facilitators' questions; asking Connect facilitators to send photos after each completed session via the WhatsApp groups; and recording which facilities have successfully completed the session.

- **Helping to prepare and implement Connect activities for the upcoming quarter:** identifying topics on which facilities would like further coaching; supporting facilitators to work with providers to set an agenda that resonates with their needs and encourages engagement. Among key decisions is whether to repeat content from the intensive phase (based on learning outcomes, provider attendance, and engagement in Connect sessions).

MATERIALS NEEDED TO IMPLEMENT IN-PERSON AND BLENDED CONNECT

To implement Connect effectively, an assortment of materials will be needed at different times by different people. Below are specific items needed and quantities of each. Examples of these materials can be found in **ANNEX 4** and noted as Additional Materials in **ANNEX 7**. Remember that all materials must be customized for your specific country setting and audience.

FOR IN-PERSON CONNECT

- Connect intensive phase curriculum modules (8, printed)
- Connect curriculum materials kit (1 per facility)


Consultation journey poster (1 per facility)
Six Principles stickers (1 set per facility)
Learning reflection cards (10 sets per facility)
Method cards (2 sets per facility)
Sign-in sheets
Markers, pens, white paper

FOR BLENDED CONNECT

- All of the above materials plus
- Smartphone and WhatsApp for digital engagement
- Digital engagement prompts (see sample Digital Connect Content Plan and Curriculum in **ANNEX 7**)

DATE: _____ La Récolte Module 1

Quelles sont deux actions que le groupe s'est engagé à prendre ensemble pour trouver une solution au préjugé envers les jeunes?

 BÂTIR L'AVENIR

Implementing Digital Connect

Training and mentorship of guest Digital Connect Moderators should occur monthly and should include:

Preparing and posting the content for the week: reviewing the proposed digital prompt for the week (see sample Digital Connect Content Plan and Curriculum in **ANNEX 7**); modifying the content, if needed, to make it more engaging for providers; confirming attendance and details for any guest experts participating the week; posting content for the week on the WhatsApp group to providers.

Moderating the resulting discussion: expect to spend 30-60 minutes a day moderating and responding to questions. If needed, engaging relevant experts to answer providers' questions.

Recording notes about providers' engagement and discussion: at the end of the week, using monitoring tools to record key engagement statistics and notes about the discussion.

Preparing for upcoming quarter's Connect activities: planning out next three months of content based on provider feedback and quarter 1 data; setting an agenda that resonates with provider needs and encourages engagement (among key decisions is whether to repeat content from the intensive phase based on learning outcomes, provider attendance, and engagement in Connect sessions); identifying and training "model providers" who may be strong guest moderators.

The Critical Role of the Connect Digital Moderator

The Connect Digital Moderator plays an important role not only in delivering content but also in creating a safe, focused space for provider dialogue. Moderators must be well-connected and resourceful, able to access technical experts and medically accurate content from credible sources to address specific questions about contraceptive methods. Having access to timely, accurate information is critical in digital Connect, where providers do not meet in person and are more likely to share forwarded or irrelevant content in the group chat. Moderators must remind providers of the ground rules and actively work with them to set boundaries. While messages related to national events, celebratory festivals, or providers achievement are often acceptable and welcome, each group must determine its own boundaries and adhere to them.

MATERIALS NEEDED TO IMPLEMENT DIGITAL CONNECT

- Smartphone with data enabled
- WhatsApp application installed on provider phones
- Connect digital moderator guide
- Connect intensive content plan (10 weeks) and curriculum



Preparing for Connect

In the three weeks leading up to Connect, the Beyond Bias coordinator, facility managers, and Connect in-person facilitators should make preparations as outlined below.

In addition to logistical preparations, Connect facilitators must be trained to organize, convene, and facilitate Connect sessions; deliver curriculum and lead facility-based discussions; and lead providers in action planning and structured review of quarterly report cards. Depending on the geographic distribution of facilities, multiple facilitator trainings may be needed. These trainings will be followed up with regular mentorship throughout implementation of the intervention.

	In-Person and Blended Connect	Digital Connect
3 WEEKS IN ADVANCE	<p>Review intensive curriculum (8 weeks).</p> <p>Set a date for facilitator training (4 hours).</p>	
2 WEEKS IN ADVANCE	<p>Prepare training agenda and engage training staff as needed.</p> <p>Invite designated staff to facilitator training.</p> <p>Print and collate the Facility Materials Kit (1 per facility) to distribute during training.</p>	<p>Review 10-week intensive phase curriculum and moderator guide in detail. Designate the primary moderator and the reply process for technical and policy questions.</p> <p>Identify and request guest speaker/expert participation within 10-week content plan.</p>
1 WEEK IN ADVANCE	<p>Confirm facilitator attendance for training.</p> <p>Conduct facilitator training (4 hours) & distribute Curriculum Kits to attendees (8 modules & support tools).</p> <p>Create a "Leaders" WhatsApp group and add facilitators by cohort.</p>	
3 DAYS IN ADVANCE	<p>Confirm with facilitators via Leaders WhatsApp group that a dedicated space in the facility is arranged and FP providers informed of the first scheduled session</p>	<p>Implement any updates to curriculum content as needed based on providers' questions at Summit events.</p> <p>Verify that all providers are registered on the WhatsApp group.</p>
DAY BEFORE CONNECT	<p>Send reminder to facilitators on materials needed and answer any questions about preparation via Leaders WhatsApp group. Prepare meeting space.</p>	<p>Review Day 1 content and test posting of any multimedia content to ensure correct visualization.</p>

Overcoming Specific Challenges During Connect: How We Refined Connect

As with any new program, we faced many challenges along the way in testing Beyond Bias approaches.

Our intention from the start, however, was to pilot innovations, learn from our experience, and feed lessons back into the intervention design so that we -and you - could benefit from program refinements. In the table below, we describe three examples of challenges that arose during Connect implementation and how we addressed the challenges. Refinements resulting from this (and other) learning have been incorporated in the guidance offered throughout this document.

Issue	Result	How we addressed the challenge
INFORMATION WAS TOO INTENSE AND TOO FREQUENT	During the intense phase of the forum, providers said they felt overwhelmed with information, that some large video files shared consumed too much of their mobile data and storage space, and that the weekly in-person meeting schedule was too demanding on their time.	We spread shared information and meetings over longer intervals and refrained from sharing large video files over mobile phones.
COMPETING PROVIDER PRIORITIES AND STAFF ROTATIONS	Difficulty for providers to consistently attend in-person Connect meetings; some participant attrition over time. This was especially the case where private providers were concerned as for them, missing an hour of work is missing an hour of earning.	We repeated sessions that were missed by many providers. This meant that it took longer to get through the entire Connect curriculum but we felt it was worth the additional time to have more providers complete the intervention.
WANING PROVIDER INTEREST AND ENGAGEMENT OVER TIME	Some providers reported that they could not maintain a high level of attention and participation in the forum over time.	We employed a variety of techniques to keep interest high including: incorporating new and exciting ways of communication using graphics, art, and doodling; nominating participants themselves to facilitate Connect discussions; holding small competitions; encouraging everyone rather than favoring a particular set of providers; and introducing a Reward category for Connect participation.



WHY DOES CONSISTENT ATTENDANCE MATTER DURING CONNECT?

Our monitoring data suggests that facility *Reward scores increase in direct proportion to facility Connect participation rates*. According to our analysis, "high levels" of Connect participation (defined as ≥66% participation in a quarter for In-Person Connect and active Connect participation in a quarter for Digital Connect) resulted in a 4 percentage point increase in Reward score in Burkina Faso, a 5 percentage point increase in Reward score in Pakistan, and a 6 percentage point increase in Reward score in Tanzania compared to "low levels" of Connect participation. These findings were shared with providers and facility managers to further encourage participation in future Connect sessions.

Tips for Overall Connect Success: Other Lessons We've Learned

	All formats	In-Person	Digital	Blended
DO	Have trusted messengers deliver technical information.	Invite senior members of the facility hierarchy as facilitators.	Invite guest speakers with medical credentials that providers recognize.	Invite senior members of the facility hierarchy as facilitators.
DO	Create and maintain a safe space where providers feel heard, respected, and valued.	Reinforce this point when training the facility-level facilitators.	State the ground rules at the beginning of the group's interactions and reinforce them throughout.	Reinforce the need for ground rules when training facility-level facilitators.
DO	Blend AYSRH content with other topics that providers care about. For private-sector providers, this might be marketing tips and business strategy; for public-sector providers, maternal and child health and HIV prevention.	Encourage Connect facilitators to adapt the youth case studies to make them feel more realistic and interesting for their providers during the continuous learning phase.	Use multi-media content formats to help sustain engagement. Audio format (WhatsApp voice notes) is strongly preferred by providers for content delivery and discussion. Photo-sharing prompts also elevate engagement and interest.	Encourage providers to casually share stories and photos with each other.
DO	Foster dialogue and learning. Providers are eager to learn and share best clinic and business practices from experts and be inspired by senior providers.	Use the WhatsApp group to share tips, respond to logistical or technical questions, and track whether the Connect sessions are happening as intended.	Have one primary, consistent moderator, especially for the first 10-week intensive phase. Consistent moderation helps build trust with the participants.	Use the WhatsApp group to share light, celebratory content.



AND THREE "DON'TS"

Don't push one-directional technical content without inviting discussion. Connect is a space for providers to listen, discuss, and problem-solve together.

Don't shame providers for a wrong answer. Connect is not about testing providers or pointing out their mistakes in front of peers.

Don't ignore provider feedback about the program. If participants are struggling to participate or are experiencing challenges, listen and try to adjust operations where possible (for example, easing the pressure on busy providers by spreading activities over a longer period of time). Listening to feedback will foster a positive team spirit and motivate participants to continue with the program.

LESSONS FROM THE FIELD: WHAT CONNECT LOOKED LIKE

IN PAKISTAN Pakistan participants were busy private sector providers who were not inclined to travel away from their clinics to meet for numerous in-person meetings and events. The team thus opted to implement the digital version of Connect, using WhatsApp as the most efficient way of communicating with providers. Post-Summit, a WhatsApp group was formed with all providers as members. The group appointed a moderator (a project staff member trained on sensitive communication, how best to deliver digital content, and how to moderate the group effectively). The team delivered a pre-tested curriculum through the WhatsApp group between Oct. 2019-Feb. 2020 and

then again from Sep. 2020-Aug. 2021 (the interruption was due to COVID-19). The curriculum was comprised of weekly thematically curated content in the form of case studies, quizzes, talks, videos, audio scripts, and infographics. Topics included:

- The Six Principles of Unbiased Care
- FP/SRH myths and misconceptions
- Serving the youth of Pakistan
- Informed choice
- Comprehensive modern FP methods
- Personal motivation of healthcare providers and The role of households in FP/SRH decision-making

IN TANZANIA Tanzania providers expressed a preference for a blended version of Connect, stating that they wanted a mix of both digital and in-person activities. For the digital activities, after the four Summits were concluded, providers were divided into two digital Connect WhatsApp groups (one group had 75 members and the other group had 66 members) and an additional WhatsApp group was formed for facility in-charges who ran in-person Connect sessions. For eight weeks, the WhatsApp groups received tailored messages around one topic per week. The topics were:

Week 1: Introduction and welcoming

Week 2: Standards of quality: adolescent care (safe space)

Week 3: Technical aspects of counselling youth clients

Week 4: Contraception, counselling and HIV/STIs

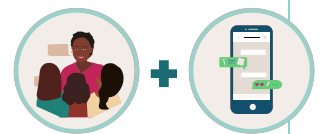
Week 5: Contraception, counselling and HIV/STIs (continued) **Week 6:** Maternal health

Week 7: Informed choice and safe methods

Week 8: Long-acting reversible methods

Digital Connect was complemented by simultaneous in-person activities. During the project's first quarter, designated, trained facility in-charges led providers through one in-person meeting per week for six weeks. Topics included: (1) refresher training on provider bias; (2) youth client case study; (3) "the story of Esther"; (4) true/false technical review; (5) a second youth client case study; and (6) a peer exchange.

Though providers and facilitators gave weekly sessions positive reviews, one issue that arose was low attendance, often due to competing demands (such as the arrival of a patient) and mismatched work shifts between providers. The team responded to this issue by changing the schedule from weekly to monthly meetings to ease the burden on participants.



PRO TIP Based on feedback from Beyond Bias project participants, internal monitoring results, and final evaluation findings, we recommend use of the blended Connect method. The combination of digital and in-person activities can be adapted to suit more adult learner types and offers more ways to reach participants with messaging.

OUTCOME: PARTICIPANT FEEDBACK ON CONNECT

IN BURKINA FASO The Beyond Bias team in Burkina Faso surveyed providers and facilitators who participated in Connect between September 2019 and March 2020, asking them what they thought about Connect. In that survey, 96% of respondents said they believed that participating in Connect sessions was a valuable use of their time. In addition, 95% of respondents said they would recommend Connect to other colleagues and 98% of facilitators said they were committed to continuing facilitation of the following week's sessions.



IN PAKISTAN Participants in Pakistan were also enthusiastic about Connect, with one saying, *"This network has given me the confidence that I am not alone, and what I am doing is not wrong. The group gives me strength to continue doing what I am doing, with confidence and courage".*

Said another, *"[Beyond Bias] is a learning platform where we were in contact with each other. We continued to share. We also got a lot of learning from each other. This platform heightened my technical knowledge and refreshed knowledge that [learned] in college".*

IN TANZANIA Meanwhile, in Tanzania, one provider described her views after participating in Connect by simply saying, *"No more babies having babies as long as I am in service".*





Implementing Rewards

Rewards is the third part of the Beyond Bias intervention.

When providers and facilities **achieve** progress in improving services for youth, they are recognized and celebrated in front of their peers. Celebration, recognition, and feedback support providers' motivation for continuous quality improvement based on the Six Principles of Unbiased Care. The core ingredients for the success of Rewards are:

- A standardized rubric based on the Six Principles of Unbiased Care for providers to work toward;
- Client feedback, captured directly after counseling;
- Institutional recognition for improvement and maintenance of quality.

Rewards events are important opportunities for recognizing facilities for progress and good performance; giving each facility feedback on areas for improvement; and gathering feedback from providers and facility managers on their experience of the intervention to date.

Rewards Objectives

Increase providers' motivation to improve services and maintain high-quality unbiased services for youth. Reinforce professional norms of quality care for youth. Improve facilities' understanding of what steps they need to take to improve performance.



WHY DOES THIS STEP MATTER?

Timely recognition and feedback supports providers' motivation for continuous quality improvement. Under the Beyond Bias model, providers are rewarded not with financial incentives but rather are paid in non-financial forms of currency such as personal pride, respect from their peers and supervisors, a sense of being valued in their workplace and community, and official professional recognition that can help with career advancement. The Rewards portion of the model helps create accountability and motivation for providers and facilities.



ABOUT REWARDS:

Rewards is a growth-oriented, non-monetary, performance-based incentive assessed through client feedback on provider behavior. Facilities receive quarterly report cards with performance data and recommendations for improvement; those with high improvement scores get public recognition for their progress. Through prototyping, the Beyond Bias team learned what types of non-financial recognition were most exciting to providers and were able to test different formats for delivering that recognition. The project also learned that rewarding facilities based on an absolute grading scale seemed to be less motivating than recognizing facilities that had achieved improvements over time (i.e., don't just recognize the "most-valuable player" but also the "most-improved player").

Implementing Rewards: How the Rewards Process Works

Rewards eligibility is determined based on provider and facility performance scores.

Client exit data is collected over the duration of the program and used to calculate performance scores (report cards). These report card scores are then used to identify Rewards recipients who are celebrated during quarterly (or on a different schedule if needed) Rewards events. The exact number and frequency of Rewards events may vary depending on your context,

resources available, participant schedules, etc.

Key steps in the Rewards process include:



Collect data from clients: At each facility, using a structured survey (see the "Perceived Person-Centeredness of FP Care" survey included in **BOX 4**), collect data from at least 10 youth clients who receive contraceptive services. The survey assesses the quality of

the client's experience compared against the Six Principles of Unbiased Care framework.



Analyze survey data and compile facility report cards:

For each facility, calculate the average score for the period in question (month, quarter, etc.) based on all completed client surveys for that period. Calculate facility scores as follows:

AVERAGE OVERALL TOTAL SCORE	Overall total score = combined score for all 14 questions in the client survey, averaged across all clients surveyed for the period in question
AVERAGE SIX PRINCIPLES OF UNBIASED CARE SCORES	Combined score for the specific questions below, averaged across all clients surveyed for the period in question 1. Safe, welcoming space = questions 7-9 2. Sensitive communication = questions 4-6 3. Simple comprehensive counseling = questions 1-3 4. Seek understanding and agreement = questions 7-8 5. Say yes to a safe method = questions 1-3 6. Security of information = question 14
AVERAGE DOMAINS OF PERCEIVED PERSON-CENTEREDNESS OF FP CARE SCORES	Combined score for the specific questions below, averaged across all clients surveyed for the period in question 1. Method Information (MI) = questions 1-3 2. Verbal Interaction (VI) = questions 4-6 3. Non-Verbal Interaction (NVI) = questions 7-9 4. Perceived Disrespect & Abuse (PDA) = questions 10-14



3

Next, rank facilities based on their average scores for the overall total to see which facilities had the highest score, which ones had the lowest score, and how each facility compared to the cohort average.

4

Then conduct a similar comparative analysis of average scores for each of the Six Principles and Domains of Perceived Person-Centeredness.

5

Use findings from these analyses to design and develop your facility report card (see example Report Card shown in **FIGURE 8**).

6

Give feedback on performance at specified times:

- Facilities, Beyond Bias organizers, and invited guests gather at offsite group Rewards events according to a specified schedule.

- At the event, facilities receive their report card.
- After the Rewards event, facility managers review report cards with their teams and identify actions to take over the coming period.
- At the end of the year (or at a different specified time), top-performing facilities (top performing by score, best improvement) receive an awards plaque and each provider receives both a merit badge and a certificate of achievement.

Preparing for Rewards

In the four weeks leading up to a Rewards event, the Beyond Bias coordinator, clinical support staff, M&E officer, and data enumerators (if any) will prepare using the timeline below as a guide.

4 WEEKS IN ADVANCE	<ul style="list-style-type: none"> • Coordinate with data team to determine feasible timeline for data analysis and reporting for each cohort. • Schedule Rewards events (1 per cohort). • Start drafting agenda and program for the Rewards event.
3 WEEKS IN ADVANCE	<ul style="list-style-type: none"> • Send invitations to facility managers, providers, and key stakeholders. • Arrange for any special entertainment or performances for event. Request letter of congratulations from senior MOH or partner representative, to be given to eligible facilities at Rewards event. Note that for the final Rewards event, a respected stakeholder (MOH or similar) should be invited to officiate to elevate the importance of the event and the value of Rewards.
2 WEEKS IN ADVANCE	<ul style="list-style-type: none"> • Support data team with data visualization and translation of performance information/measurements to report cards.
1 WEEK IN ADVANCE	<ul style="list-style-type: none"> • Print final report cards for sharing with facility managers and providers. • Identify which and how many facilities qualify for Rewards. Assemble the Rewards kit for qualifying facilities. • Print letters of congratulations from MOH or other officials to be included in Rewards kit.



PRO TIP

Engaging stakeholders in Rewards increases potential for provider adoption, sustainability, and scale-up:

To encourage public sector engagement, invite district-level MOH representatives to Rewards events. Arrange meetings to share updates on data and facility performance. Invite MOH regional representatives to be "co-signers" on Rewards certificates. Invite a national-level MOH representative to be a distinguished guest at the final end-of-year Rewards event.

If working in the private sector, invite key stakeholders to Rewards events. Arrange meetings to share an overview of client exit survey data and facility performance. Review report card content, performance data, program progress, and explore how Rewards data can be integrated into existing quality reporting systems. Invite a national-level stakeholder (public or private sector) to be a "distinguished guest" at the final, end-of-year Rewards event.

MATERIALS NEEDED TO IMPLEMENT REWARDS

To implement Rewards effectively, an assortment of materials will be needed at different times by different people. The table below lists specific items needed and quantities of each. Examples of some of these materials can be found in **ANNEX 5**. Remember that all materials must be customized for your specific country setting and audience.

FOR DATA COLLECTION:

Client exit survey tool
(see **BOX 4**)

Tablets for data collection
with survey application installed
(optional; 1 per enumerator —
see next page for considerations
regarding working with
enumerators)

**Facility manager training
modules**

**REWARDS EVENT
SLIDE DECK AND AGENDA**

AT EACH REWARDS EVENT, FACILITY MANAGERS WILL RECEIVE THE FOLLOWING:

Facility-level report card

(see example in **FIGURE 8**).

Each facility receives a report card on their performance at months 4, 8, and 12. The report gives each facility information on the following:

- Their performance on each of the Six Principles of Unbiased Care as well as an average score across the Six Principles
- How they compare to the average performance of the other facilities in their cohort
- How they compare to unbiased facility standards

Recommendations for improvement

Rewards ceremony kit. Facilities that qualify for Rewards each quarter get a Rewards kit. These should be given to facility managers to use during the facility-level Rewards ceremony.

- Envelope with Rewards sticker (with facility name written in)
- Merit pins for each provider (attached to pin-backing cards)
- Report cards (printed in color; print 3-5 copies per facility for multi-provider facilities)
- Letter of congratulations from senior MOH or partner representative as appropriate (1 per facility)

Guide for facility managers on how to facilitate the facility-level Rewards ceremony



Overcoming Specific Challenges During Rewards: How We Refined Rewards

As described earlier in the Connect section, operational challenges also arose during Rewards implementation. The table below describes specific examples of challenges we faced and how we addressed the challenges. As with refinements made to the design of the Connect intervention, improvements made to the design of Rewards have been incorporated in the guidance offered throughout this document.

Issue	Result	How we addressed the challenge
SOME PROVIDERS AND FACILITIES NOT GETTING RECOGNIZED	Motivation among unrecognized participants started to lag.	Initial Rewards ceremonies focused on prizes and recognition for facilities with the top three highest Reward scores. In subsequent Rewards ceremonies, we expanded Rewards categories to include "Most improved Rewards score" and "Best Connect participation". Another way to ensure that more facilities get recognized is to have more (but smaller) facility cohorts. Having fewer facilities in each cohort increases the odds that any given facility will be recognized over time.
LOW PARTICIPANT TURNOUT DURING REWARDS EVENTS	Rewards events were not as celebratory as desired; was difficult to foster enthusiasm and healthy competition among attendees.	We incorporated other activities that were of interest and beneficial to providers into Rewards events, for example, sessions on health and wellness, meditation, and business development.
SOME PROVIDERS UNCLEAR ON REWARDS SCORING AND RANKING SYSTEM	Lack of clarity on how Rewards system worked decreased participant motivation and commitment to the program.	We increased efforts to communicate how the Rewards system worked, utilizing all "touch points" with participants.
LOW YOUTH CLIENT FLOW IN THE HEALTH FACILITIES	Provider and facility performance could not be assessed if no youth clients came for services. Without clients, there was no basis to calculate a report card and no basis for earning Rewards.	We supported implementation of rigorous, focused demand-generation activities in communities, for example, by mobilizing youth peers at wedding halls and beauty parlors.
USE OF YOUTH ENUMERATORS TO CONDUCT CLIENT EXIT INTERVIEWS	The need for youth enumerators to conduct client interviews places an additional operational and financial requirement on the project, which reduces scalability of the approach.	We developed a short, user-friendly provider performance assessment tool (see BOX 4) that can be integrated into existing data collection systems or administered digitally, thus eliminating the need for an additional youth enumerator cadre.

Certainly, more work is needed to find cost-effective ways of collecting credible and reliable client facing data. Though using enumerators enabled us to implement and rigorously evaluate the Beyond Bias model, we recognize the operational and financial burden of this approach which limits scalability of the Rewards pillar as we implemented it. As such, we suggest integrating our newly developed short and user-friendly provider performance assessment tool (see **BOX 4**) into existing data collection systems in a way that eliminates the need for an additional youth enumerator cadre. For instance, in Burkina Faso we learned community health workers are engaged in collecting facility-based data regularly at the district level. In Tanzania, health facilities have assigned mentors who pay regular site visits to assess their needs and performance. In Pakistan, Greenstar Social Marketing (GSM) franchise collects data on providers within their network. These examples provide opportunities for integrating the

provider performance tool. Alternatively, digital data collection could be an option in some contexts in the near future with advances in mobile phone access and use. Another option would be use of mystery clients, especially in contexts with very low youth client volume.

However, any promising solutions, including those outlined herein, should be explored with the following caveats in mind: i) data falsification or lack of objectivity is a major challenge where facility assessment is managed internally; ii) some clients may not be comfortable providing their contact information for follow-up interviews, especially in contexts where phone-sharing is common or for clients who use contraceptives covertly; iii) clients with low literacy levels may have difficulties responding to a digital survey accurately; and iv) mystery clients would need to be well-trained and their visits spread out to avoid being found out.

BOX 4. How Do You Calculate Facility and Provider Performance Scores?

Beyond Bias-supported facilities are rewarded for delivering high-quality client care, as defined by the Six Principles of Unbiased Care Framework. During the Rewards phase, provider performance is measured through client exit interviews using a specialized questionnaire developed by the Beyond Bias team. The user-friendly, 14-item survey questionnaire (tool) was designed to yield rigorous, validated client-assigned scores to providers and to reliably reflect how well providers adhered to the

principles of person-centered FP care. The survey can be administered to clients by health workers. During the Rewards phase, your Beyond Bias team can use the tool as an intervention (in other words, you can use the tool to calculate an individual provider's score which is then used as a basis for timely feedback) as well as a quality monitoring tool (i.e., you can collect aggregated, averaged scores across groups of providers or facilities and use this data to identify and address performance issues).

WHAT DOES THE TOOL LOOK LIKE?

As shown at right (see also ANNEX 6), the tool assesses the respondent's level of agreement to key statements based on their recent FP care experience.

HOW IS EACH QUESTION SCORED?

For Domains 1, 2a and 2b:

0-Strongly Disagree

1-Partially Disagree

2-Neither Disagree nor Agree

3-Partially Agree

4-Strongly Agree

For Domain 2c:

5-Strongly Disagree

4-Partially Disagree

3-Neither Disagree nor Agree

2-Partially Agree

1-Strongly Agree

No.	Questions	MIN SCORE	MIN SCORE
Perceived Person-Centeredness of FP Care (PPCFP = MI + PI)		0	56
Domain 1: Person centeredness of Method Information (MI)		0	12
1	Did the provider ask you if you had any questions?	0	4
2	Were you told what to do if you experienced side effects or problems?	0	4
3	Did the provider give you information about what to do if you wanted to stop using the method?	0	4
Domain 2: Person centeredness of Provider Interaction (PI = VI + NVC + PDA)		0	44
Sub-Domain 2a: Person centeredness of Verbal Interaction (VI)		0	12
4	Did the provider you saw for family planning allow you to give your opinion about what you needed?	0	4
5	Did the provider you saw for family planning consider your personal situation when advising you about PF methods?	0	4
6	Did the provider you saw for family planning give you the time you needed to consider the contraceptive options they discussed?	0	4
Sub-Domain 2b: Person centeredness of Non-Verbal Interaction (NVI)		0	12
7	Did you feel the provider you saw your family planning cares about you as a person?	0	4
8	Did you feel like the provider you saw for family planning involved you in decisions about your FP choice?	0	4
9	Was the provider interested in your opinions?	0	4
Sub-Domain 2c: Perceived Disrespect and Abuse (PDA)		0	20
10	Did you feel the provider judged you?	0	4
11	Did you feel the provider scolded you?	0	4
12	Did the provider make you feel uncomfortable because of your sex life (moral paternalism and judging)?	0	4
13	Did the provider pressure you to use the method they wanted you to use? (Method bias)	0	4
14	When meeting with the provider during your visit, do you think other clients could see you?	0	4

LESSONS FROM THE FIELD: WHAT REWARDS LOOKED LIKE

Like all country teams, the Pakistan team collected facility and provider performance data on a quarterly basis via trained youth enumerators. At the end of each quarter, the team used collected data to complete facility and individual provider report cards (see **FIGURE 8** below). Report card scores were used to assess best performing facilities and providers and identify those eligible for rewards.

For the period Sept. 2019 to Feb. 2020, the team issued four performance-based awards to facilities and individual providers at a Rewards ceremony. For example, one facility received an award for "overall best performance" and one provider received a special reward for being the "most active participant on the Digital Connect WhatsApp group". The "overall best performance" award was given out by local celebrity guest Sania Saeed. All providers received a detailed progress report card which they appreciated and said that they left the Rewards

event feeling motivated to perform better in the coming quarter.

As additional incentive, facilities that achieved one quarter of strong performance also received a certificate of excellence by Greenstar (a private sector network in Pakistan); professional recognition on Greenstar's website, newsletter, and Facebook page; and priority access to Greenstar events, trainings, and business resources. Facilities achieving two quarters of strong performance received all of the above plus priority access to inter-personal counseling support and an invitation as an honored guest to the Greenstar quarterly company meeting.



FIGURE 8. An actual report card given to a facility during a Rewards event. This facility's overall score for the quarter is shown at left (72%), and on the right side, graphs show the facility's scores in performing the Six Principles of Unbiased care relative to cohort average scores and target (model) scores. The text in the bottom right corner summarizes recommendations for facility improvements.

Group: 1 (Ittehad)
Performance Timeframe: Sep 8, 2020 - Jan 10, 2021
Number of FP youth clients: 13

Your overall score:

72%

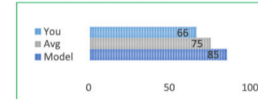
13 to reach
Points model unbiased care

- 😊 Maintain success
- 😊 Making Progress
- ☹ Need improvement

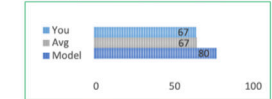


Your Performance on the Six Principles of Unbiased Care

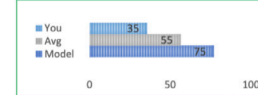
P1. خوش آمدید کہنے کے لیے محفوظ جگہ



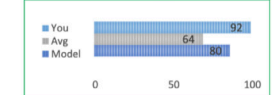
P2. جنس بات چیت



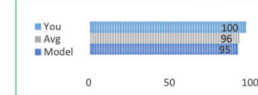
P3. بات کو سمجھانے اور الفاظ رائے حاصل کیجئے



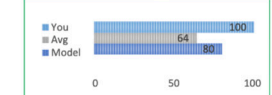
P4. معلومات کا تحفظ



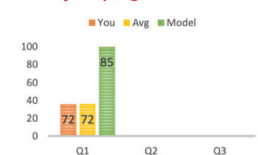
P5. محفوظ طریقے کے لیے "ہاں" کہئے



P6. سادہ، جامع بات چیت



Track your progress



بہتری کے لیے نکات

- اس بات کو یقینی بنائیں کہ کلائنٹ خوش آمد ہوں
- یاد رکھیں کہ یونٹ کلائنٹ کے شریک حیات اور والدین سے خاندانی منصوبہ بندی کا طریقہ استعمال کرنے کی اجازت طلب کرنا آپ کی خدمات کو متعصب بنا دیتا ہے۔
- اس بات کو یقینی بنائیں کہ نوجوان کلائنٹ سے ان کے پسندیدہ خاندانی منصوبہ بندی کے طریقہ کے بارے میں ضرور پوچھا جائے۔

LESSONS FROM THE FIELD: WHAT REWARDS LOOKED LIKE

IN TANZANIA As in Pakistan, the Tanzania team identified Reward-winning facilities based on facility report card scores. The facility with the highest marks during a quarter was designated the overall winner. Other awards included recognition for:

- Being one of three top performing facilities within a district, with the first-place scorer given a certificate and the second- and third-place scorers given public recognition,
- Being the best facilitator of an In-Person Connect group, and
- Contributing the most consistently in Digital Connect group sessions.

Rewards events included time for celebration as well as reflection and sharing of best practices. Participants also enjoyed a sense of healthy competition that developed between facilities, with all pledging to "be on top" in coming quarters. Providers said they particularly appreciated receiving personal report cards and being recognized publicly by their superiors.



"Today's recognition has motivated me more. I have been made a youth focal point in my facility in providing quality and friendly service. I will put more effort into participating in [Beyond Bias] sessions, they have built me more in my career."

—TANZANIAN PROVIDER

Tips for Overall Rewards Success: Lessons We've Learned

DO highlight for providers that increased personal pride, a greater sense of being valued and recognized at work, and being able to make a positive difference for youth clients in their community are valuable rewards for their hard work and commitment.

DO celebrate facilities for their growth and improvement while communicating the need to meet a clear set of standards (the Six Principles of quality, unbiased care).

DO give specific feedback on where facilities can improve and recommendations for what actions to consider taking.

DO include a skills refresher activity for multi-provider facility managers during Rewards events to maintain their skills in effectively conducting

a report card review and action planning activity with their teams.

DO encourage facilities to share best practices and tips to improve performance.

DO seek buy-in and support from key institutional stakeholders whom providers respect to encourage continued high performance.

DO use Rewards events as an advocacy tool. For example, the Burkina Faso team invited Members of the National Assembly and Presidents of the Regional Councils to their final Rewards event, where they saw firsthand what Beyond Bias was about. The team used the guests' presence as an opportunity to advocate for adoption of interventions to reduce provider bias.

STEP

6

Performance Monitoring, Evaluation, and Learning

Because the Beyond Bias project was designed to be a learning project, rigorous monitoring, evaluation, and learning (MEL) protocols, tools, and systems were deployed to ensure that the team could identify not only “what worked” versus “what didn’t work” within the model, but also to facilitate continuous tracking of team progress.

Over the life of the project, the team’s MEL activities allowed for rigorous measurement and evaluation of the model’s effectiveness and potential for institutionalization and scale-up.

To support monitoring and evaluation of Beyond Bias implementation in your setting, we provide a set of indicators on the next page that you can use to track performance.



WHY DOES THIS STEP MATTER?

As with all public health programs, when implementing the Beyond Bias model you will want to establish an internal performance monitoring system that enables your team to track its progress; learn from implementation experience; make timely, targeted program refinements when needed; and report performance information to stakeholders.

Having a system, tools, protocols, and trained personnel available to monitor program performance will help ensure that valuable program resources are used efficiently and effectively and that chances of program success are improved..

CONTRIBUTING TO THE GLOBAL KNOWLEDGEBASE AND ADVANCING THE SCIENCE

As you implement Beyond Bias, priority should be placed on documenting and disseminating learning that you generate. By sharing lessons learned, examples of best practices and new tools, and key operational insights, your team will be contributing to the global knowledge base pertaining to provider bias reduction. Additional information is needed to advance the science of not just implementing effective provider bias reduction solutions but also the science of bias measurement. Without sensitive and specific bias measurement tools for example, reliably detecting behavior change among providers and clients and/or quantifying the magnitude of intervention impact will be a challenge.



Indicators: Measuring Solution Implementation

The following indicators were used to measure Summit, Connect, and Rewards implementation under the Beyond Bias project.

Data were collected for various indicators through internal process documentation and facility/provider engagement; qualitative surveys and interviews; structured debriefings with participants; and standardized training and event reporting forms.

Indicators you might adopt include:

# & % project facilities and providers who attended Summit (by cohort)	# & % of providers who attend facility Rewards event
Level of engagement among providers in Summit	# & % of facilities that complete the facility-level Rewards ceremony
# & % of moderators trained on Connect modules	# & % of facilities that have management staff present at facility Rewards events
# & % of Connect modules completed	Level of enthusiasm for recognition & Rewards artifacts
% of providers who stated that the Connect session was a valuable use of their time	Degree of difficulty in execution as perceived by implementers
% of providers who would recommend Connect event to their colleagues	



Under the Beyond Bias project, frequency of data collection for these indicators was:

Once per event (Summit)	Monthly (Connect continuous learning phase)
Weekly (Connect intensive phase)	Quarterly (Rewards)

Data collection timing should be adapted to your team's needs, if for example, you have changed the timing of Connect or Reward activities.



Indicators: Outcomes and Impact

Clients receive the method of their choice

Clients are treated in a non-judgemental, non-biased manner
Clients are counseled on a full range of modern methods

% of clients to whom service was refused

% of clients who felt welcomed by the health provider

% of clients who were invited to ask questions by the provider

% of clients who were asked if they had received spousal/family permission to access services

% of clients who were asked about their preferred FP method

% of clients who felt they were given privacy

% of clients who were discouraged from using a FP method

% of clients who felt satisfied with their chosen FP method

% of clients with whom both short-acting and long-acting methods were discussed

% of clients who felt forced to choose a method

of new modern contraceptive users at facilities by age (15-19, 20-24) and by method

of repeat visits for modern contraception at facilities, by age (15-19, 20-24) and by method

% of youth clients aged 15-24 reporting that they received their contraceptive method of choice

% of youth clients who received long-acting, reversible contraceptives





ANNEXES

1. Psycho-Behavioral Segmentation Tools:
Pakistan and Burkina Faso
2. Sample Summit Facilitator Agenda
3. Sample Summit Implementation Materials
4. Sample In-Person Connect
Implementation Materials
5. Sample Rewards Implementation Materials
6. Perceived Person-Centeredness of FP Care Tool
7. Additional Implementation Materials
8. Supplemental Publications

ANNEX 1. Psycho-Behavioral Segmentation Tools: Pakistan, Burkina Faso, and Tanzania

PAKISTAN CLASSIFICATION TOOL

Beyond Bias Classification Tool Example: Pakistan

Q#	Questions in Section 1
	<p>I'd like to ask your opinion on a few things. I'm going to read you some opinions that people have, and ask for your opinion too.</p> <p>This isn't a test, there are no right or wrong answers. As a reminder, when I say youth or young person, I mean someone aged 15-24, unmarried or married, which is how WHO defines this term.</p> <p>There are five ways that you can respond:</p> <p>strongly disagree, disagree, neutral, agree, or strongly agree. Please choose one response for each statement that shows your opinion.</p>
Q1	<p>PROVIDING CONTRACEPTIVES FOR UNMARRIED YOUNG PEOPLE MAY MAKE THEM MORE PROMISCUOUS.</p> <p>01. Strongly agree [continue] 02. Agree [skip to Q6] 03. Neutral [skip to Q6] 04. Disagree [skip to Q8] 05. Strongly Disagree [end = Paternalistic Clinician]</p>
Q2	<p>I'M PAID FAIRLY FOR THE WORK THAT I DO.</p> <p>01. Strongly agree [end = Content Conservative] 02. Agree [end = Content Conservative] 03. Neutral [continue] 04. Disagree [continue] 05. Strongly Disagree [continue]</p>
Q3	<p>MY RELIGION CONSIDERS IT A SIN FOR UNMARRIED GIRLS TO USE CONTRACEPTION.</p> <p>01. Strongly agree [end = Content Conservative] 02. Agree [end = Content Conservative] 03. Neutral [continue] 04. Disagree [continue] 05. Strongly Disagree [continue]</p>
Q4	<p>HAVE YOU USED ANY METHODS OF FAMILY PLANNING, EITHER CURRENTLY OR IN THE PAST?</p> <p>01. Yes, mentions IUD [continue] 02. Yes, does not mention IUD [end = Average Passive] 03. No, never used any methods [end = Average Passive] 04. No response / refused to answer [continue]</p>

PAKISTAN CLASSIFICATION TOOL (CONT.)

Q#	Questions in Section 1 (cont.)
Q5	<p>YOUNG WOMEN WITHOUT CHILDREN SHOULD NOT USE ANY PRODUCT THAT MIGHT CAUSE A DELAY IN FERTILITY ONCE STOPPED.</p> <p>01. Strongly agree [end = Content Conservative] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly Disagree [end = Average Passive]</p>
Q6	<p>YOUNG WOMEN WITHOUT CHILDREN SHOULD NOT USE ANY PRODUCT THAT MIGHT CAUSE A DELAY IN FERTILITY ONCE STOPPED.</p> <p>01. Strongly agree [end = Content Conservative] 02. Agree [continue] 03. Neutral [continue] 04. Disagree [continue] 05. Strongly Disagree [continue]</p>
Q7	<p>AS A PROVIDER, I HAVE A RESPONSIBILITY TO TEACH YOUNGER PEOPLE HOW TO BEHAVE.</p> <p>01. Strongly agree [end = Content Conservative] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly Disagree [end = Average Passive]</p>
Q8	<p>ACCORDING TO MY RELIGIOUS BELIEFS, IT IS OKAY FOR ONE TO LIMIT HOW MANY CHILDREN THEY HAVE.</p> <p>01. Strongly agree [end = Paternalistic Clinician] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly Disagree [end = Average Passive]</p>

BURKINA FASO CLASSIFICATION TOOL

Beyond Bias Classification Tool Example: Burkina Faso

This tool is a simplified Chi-squared Automatic Interaction Detector model, built from a multivariate survey of health providers in Burkina Faso.

Q#	Question
Q1	I ENJOY WORKING WITH YOUNG CLIENTS IN GENERAL. 01. Strongly Agree [skip to Q2b] 02. Agree [skip to Q2a] 03. Neutral [Average Passive] 04. Disagree [skip to Q2c] 05. Strongly Disagree [Sympathetic Guardian]
Q2a	A CLIENT WITH JUST ONE DAUGHTER WILL HAVE DIFFERENT FAMILY PLANNING NEEDS THAN A CLIENT WITH JUST ONE SON. 01. Strongly Agree [Detached Professional] 02. Agree [Average Passive] 03. Neutral [skip to 3a] 04. Disagree [skip to Q3a] 05. Strongly Disagree [Detached Professional]
Q2b	YOUNG WOMEN WITHOUT CHILDREN SHOULD NOT USE ANY PRODUCT THAT MIGHT CAUSE A DELAY IN FERTILITY ONCE STOPPED. 01. Strongly Agree [Impromptu Sister] 02. Agree [Sympathetic Guardian] 03. Neutral [Sympathetic Guardian] 04. Disagree [Sympathetic Guardian] 05. Strongly Disagree [Sympathetic Guardian]
Q2c	YOUNG WOMEN WITHOUT CHILDREN SHOULD NOT USE ANY PRODUCT THAT MIGHT CAUSE A DELAY IN FERTILITY ONCE STOPPED. 01. Strongly Agree [Sympathetic Guardian] 02. Agree [skip to 3b] 03. Neutral [skip to 3b] 04. Disagree [skip to 3b] 05. Strongly Disagree [skip to 3b]
Q3a	PROVIDING CONTRACEPTIVE SERVICES TO YOUTH MAKES ME WORRY ABOUT MY CLINIC'S REPUTATION IN THE COMMUNITY. 01. Strongly Agree [Detached Professional] 02. Agree [Detached Professional] 03. Neutral [Average Passive] 04. Disagree [Average Passive] 05. Strongly Disagree [Average Passive]
Q3b	PROVIDING CONTRACEPTIVE SERVICES TO YOUTH MAKES ME WORRY ABOUT MY CLINIC'S REPUTATION IN THE COMMUNITY. 01. Strongly Agree [Detached Professional] 02. Agree [Detached Professional] 03. Neutral [Average Passive] 04. Disagree [Average Passive] 05. Strongly Disagree [Detached Professional]

TANZANIA CLASSIFICATION TOOL

Beyond Bias Classification Tool Example: Tanzania

Q#	Questions in Section 1
<p>I'd like to ask your opinion on a few things. I'm going to read you some opinions that people have, and ask for your opinion too.</p> <p>This isn't a test, there are no right or wrong answers. As a reminder, when I say youth or young person, I mean someone aged 15-24, unmarried or married, which is how WHO defines this term.</p> <p>There are five ways that you can respond: strongly disagree, disagree, neutral, agree, or strongly agree. Please choose one response for each statement that shows your opinion.</p>	
Q1	<p>CERTAIN FP METHODS ARE NOT APPROPRIATE FOR RELIGIOUS CLIENTS</p> <p>01. Strongly agree [continue] 02. Agree [continue] 03. Neutral [continue] 04. Disagree [continue] 05. Strongly disagree [skip to Q8]</p>
Q2	<p>UNMARRIED YOUTH CLIENTS REQUIRE CONSENT FROM THEIR PARENTS BEFORE CONTRACEPTIVES ARE PROVIDED.</p> <p>01. Strongly agree [continue] 02. Agree [continue] 03. Neutral [continue] 04. Disagree [continue] 05. Strongly disagree [skip to Q6]</p>
Q3	<p>IUDS ARE APPROPRIATE FOR YOUNG WOMEN WITHOUT CHILDREN</p> <p>01. Strongly agree [end = Average Passive] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [continue]</p>
Q4	<p>I PREFER NOT TO PROVIDE AN FP METHOD TO A CLIENT IF THEY WILL NOT TAKE AN HIV TEST</p> <p>01. Strongly agree [end = Average Passive] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [continue]</p>

TANZANIA CLASSIFICATION TOOL (CONT.)

Q#	Questions in Section 1 (cont.)
Q5	<p>AT TIMES IT CAN BE EMBARRASSING FOR ME TO DISCUSS SEX WITH YOUNGER CLIENTS.</p> <p>01. Strongly agree [end = Average Passive] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [end = Impromptu Sister]</p>
Q6	<p>I ENJOY WORKING WITH YOUNG CLIENTS IN GENERAL/NINAFURAHIA KUFANYAKAZI NA WATEJA VIJANA</p> <p>01. Strongly agree [continue] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [end = Average Passive]</p>
Q7	<p>YOUNG WOMEN WITHOUT CHILDREN SHOULD NOT USE ANY PRODUCT THAT MIGHT CAUSE A DELAY IN FERTILITY ONCE STOPPED</p> <p>01. Strongly agree [end = Impromptu Sister] 02. Agree [end = Impromptu Sister] 03. Neutral [end = Impromptu Sister] 04. Disagree [end = Impromptu Sister] 05. Strongly disagree [end = Sympathetic Guardian]</p>
Q8	<p>A CLIENT WITH JUST ONE DAUGHTER WILL HAVE DIFFERENT FP NEEDS THAN A CLIENT WITH JUST ONE SON.</p> <p>01. Strongly agree [end = Average Passive] 02. Agree [end = Average Passive] 03. Neutral [end = Average Passive] 04. Disagree [end = Average Passive] 05. Strongly disagree [continue]</p>
Q9	<p>OTHERS HAVE EXPRESSED THEIR DISAPPROVAL TO ME ABOUT THE CONSULTATIONS I PROVIDE TO YOUNG GIRLS ABOUT FP</p> <p>01. Strongly agree [continue] 02. Agree [continue] 03. Neutral [continue] 04. Disagree [continue] 05. Strongly disagree [end = Sympathetic Guardian]</p>
Q10	<p>PROVIDING CONTRACEPTIVES FOR UNMARRIED YOUNG PEOPLE MAY MAKE THEM MORE PROMISCUOUS.</p> <p>01. Strongly agree [end = Impromptu Sister] 02. Agree [end = Impromptu Sister] 03. Neutral [end = Impromptu Sister] 04. Disagree [end = Impromptu Sister] 05. Strongly disagree [end = Sympathetic Guardian]</p>

ANNEX 2. Sample Summit Facilitator Agenda

Time	Section	Duration	Activity	Description	Lead	Notes	Materials
7:30 AM	Core organizing team and Logistics team arrive		Logistics: Set up audio and projection. Team: set up tables and registration area	- Seating is pre-assigned by table **Providers should NOT be sitting with colleagues from their same facility. Facilities should be mixed.**	Logistics Lead		
8:00 AM	Entire team arrives	0:30:00	Set up tables for participants Set up audio system with music	- Tables should be spaced evenly around the room. Set up 7-9 seats per table - Music should be upbeat and fun	[Facilitators + Support team members]		
8:30 AM	Registration begins	0:30:00	Check-in	Participants arrive to the venue and are directed to the main registration table where they will be receiving a name tag, agenda, notebook, and Six Principles Booklet. They must provide their phone number for WhatsApp.	2 support team members		Attendance list Name tags Participant agendas Six Principles booklets
9:00 AM	First call to convene	0:05:00	MC makes the first call to start at 9 am	Facilitators make sure their tables are ready to start, and invite their participants in their assigned tables	[Emcee]		
9:05 AM	Welcome	0:05:00	Welcome + invitation to engage	MC makes a quick intro of the event, welcomes everyone and thanks them for their punctuality and assistance, briefly introduces the VIP speaker. At this time the MC also presents the "ground rules" to the people.	[Emcee]		Slide deck
	Agenda + Ground Rules	0:05:00			[Emcee]		
9:10 AM	Introductions	0:20:00	Ice-breaker introduction	Everyone shares their names and their favorite thing to do outside of work.	[Emcee]		
9:30 AM	Energizer	0:05:00			[Emcee]		
	Administrative announcements	0:05:00			[Emcee]		
9:30 AM	Guest speaker	0:20:00	Guest Speaker	VIP / Guest Speaker welcomes everyone to the event and gives an energizing, inspiring speech on why we should focus on improving services to youth clients.	[Emcee]	- Speech from national-level figure should be delivered via video - If MOH district representative is present, they should speak, too.	
9:50 AM	Video Story #1	0:10:00	Story #1: Young Girl	Video of young girl sharing about impact of refusal of service	IT support person		Youth Story
10:00 AM	Reflection Activity 1	0:25:00	Cause-Effect Tree	Table facilitators guide small groups in reflection on the root causes of the denial of service.	Table Facilitators	*Make sure to probe on providers' role in the outcomes for the young person*	Marker Post-its Cause-effect tree poster
10:25 AM	Reflection Activity 1- Discussion at Tables	0:05:00	Summarize key points at tables	Each facilitator guides their team to the understanding the key points of the exercise. One participant should summarize the key points from the group.	Table Facilitators		
10:30 AM	Buffer	0:10:00					
10:40 AM	Break	0:30:00		- Remind participants that refreshments are available. - Play music over audio system during break	[Emcee]		
11:10 AM	Presentation what is Bias	0:25:00	Presentation: What is provider bias and why is it important to look at?	What is provider bias? During this section, a respected technical person from Pathfinder presents the data about provider bias and how this affects the young clients when they come in for a consultation.	Respected technical trainer or clinical staff member		Slide deck Speakers notes
11:35 AM	Reflection Activity 2	0:25:00	Individual reflection activity + anonymous sharing	- Participants are guided by moderator write a story (anonymously) about a time that they were biased in their service towards youth. - Moderator reads aloud 4-5 stories in group of room.	Respected technical trainer or clinical staff member	Supported by table facilitators	Paper Pens
12:00 PM	Group Discussion	0:20:00	Full group summary reflection	Presenter facilitates a group discussion and invites participants to share any reflections after hearing their peers' stories.			
12:20 PM	Energizer	0:05:00	Song or quick game		[Emcee]		
12:25 PM	Overview of Tunda	0:15:00	Presentation: What is the Tunda program?	Introducing the concept and the pillars of the program	[Emcee or program coordinator]		Slide deck Speakers notes
12:40 PM	Quick Feedback	0:05:00	Questions	Invitation for questions and clarifications	[Emcee or program coordinator]		
12:45 PM	Six principles of unbiased care	0:20:00	Present the 6 principles of quality care to providers	Introduce the Six Principles to the providers and give some examples. Make it interactive and engaging!	Respected technical trainer or clinical staff member	Ask participants to look for their principle cards booklet	Use banner with principles as support.
1:05 PM	Buffer	0:10:00					
1:15 PM	Lunch	1:00:00					
2:15 PM	Reflection Activity 3	0:30:00	6 principles stories: Harriet and Salama	Providers reflect on stories of Harriet and Salama. Providers will be prompted to reflect upon the areas where the principles have been violated, and what behaviors could be done instead.	Table Facilitators	**PI Coordinator needs to add all participants to the Tunda Connect WhatsApp group for this cohort of facilities (2 Summits per cohort) in preparation for the next session.	Six principles booklet Copy of youth and provider stories Pens and markers Visual journey board (large blank poster papers, 1 per table) Post-its or small pieces of paper Small Six Principles cards Tape / pins
2:45 PM	Summarize the key points and takeaways	0:05:00	Discuss the results and summarize key points	Choose 2-3 participants to reflect upon the answers their colleagues have marked on the visual journey map and reflect on why	Table Facilitators		
2:50 PM	Energizer	0:05:00	Energizer	Game or group song to get participants moving and laughing!	[Emcee]		
2:55 PM	Action Planning Introduction	0:05:00	MC will introduce the action-planning activity	The MC will introduce the action planning exercise. Each participant will identify two actions that they can take and write it on their card.	[Emcee]		Action planning cards
3:00 PM	Reflection Activity 4: Reflection & Action Planning	0:10:00	Reflect on bias and outline 2 actions in commitment card	Reflect on how bias shows up and commitment to two actions. 5 minutes to for each person to share their commitment with their table.	Table Facilitators		
3:10 PM	Getting Started on Tunda Connect	0:05:00	Participants post photos on Tunda Connect.	Participants engage with Tunda Connect and post their commitment card photos to the WhatsApp group	Table Facilitators	**All participants must be added to the WhatsApp group by PI coordinator BEFORE this activity happens	
3:15 PM	Next steps of the program	0:15:00	Explain next steps of the program and linking Summit to Connect	MC will explain the next steps, the inspirational materials, and the collection of data and the rewards.	[Emcee or program coordinator]		
3:30 PM	Questions	0:05:00		Clarify any questions that providers have			
3:35 PM	Public Commitment	0:15:00	Commitment ceremony	Invite participants to front of room (by table) to and collect a pin and make a commitment to the program.	[Emcee]		Commitment pins
3:50 PM	Song / Energizer	0:05:00	Tunda chant!	End the event on a high-energy, celebratory note	[Emcee]		
3:55 PM	Facilitated group Feedback	0:15:00	Survey + provide qualitative feedback about the event		Facilitators		Survey (PI, BERI)
4:10 PM	Close	0:10:00			[Emcee]		

ANNEX 3. Sample Summit Implementation Materials

SIX PRINCIPLES OF UNBIASED CARE CARDS


<p>Eneo safi na linalovutia</p> <p>Safe welcoming space</p>	<p>Usalama wa Taarifa</p> <p>Security of Information</p>	<p>Mawasiliano yanayojali hisia</p> <p>Sensitive Communication</p>
<p>Ushauri Rahisi Uliokamilika</p> <p>Simple, Comprehensive Counseling</p>	<p>Sema Ndiyo kwa Njia Salama</p> <p>Say Yes to a Safe Method</p>	<p>Tafuta kuelewa & kukubaliana</p> <p>Seek Understanding & Agreement</p>

ACTION PLANNING CARDS

NAME: _____ FACILITY: _____

What are two ways that bias can show up when you are counseling a youth client on contraceptive methods?

What are two actions that you will take to address these biases in your own practice?


BÂTIR
L'AVENIR

ANNEX 3. Sample Summit Implementation Materials (cont.)

INSPIRATION POSTER



SIX PRINCIPLES POSTER



GUIDE FOR RECORDING SUMMIT VIDEO STORIES

Guidelines for Recording Youth Video Stories for Summit

Developing youth video content

- Create a profile of a youth you would like to feature during the Summit as a example of a youth client. The ideal candidate will be female, between the ages of 15-24, and someone who can tell her story clearly in front of a camera.
- Draft an outline for a script of the type of youth story you want to tell at the Summit. The details of the script can be revised later once you have selected your storyteller.
- Research and assess local CSOs that work directly with youth who match this profile. Reach out to one or more CSOs and share the profile content and objective of the video to determine their suitability for and interest in participating.
- Once you have selected a CSO to work with, collaborate with the CSO to interview a group of youth who fit the desired profile. Review the objective of the video and draft script with three final candidates that you have selected based on their profiles and stories. Hold a session to pre-record sample videos from the finalist candidates.
- Review the sample videos to determine which storyteller you would like to move forward with. You are looking for a real story that will be impactful for health care providers. Her story should demonstrate the consequences a provider's attitude had on her when she sought a contraceptive method or family planning counseling and services.
- Select one candidate for the final production. In collaboration with the CSO and the selected youth, decide on details of the story she will tell about her experience as a family planning client. The story should be a realistic example of what it is like to be a youth client seeking family planning services from providers in your specific context.
- Create a storyboard showing the details of her story and how she will tell it. An impactful story will demonstrate how the provider's attitude and bias towards youth clients impacted her personally. The tone of the story should carry the weight of these consequences, elicit empathy from the audience, and facilitate an understanding of the connection between youth clients and providers.
- Finalize the script and move into production.

Producing the video

- Determine the budget for video production. Producing the video internally is more cost effective but may not be feasible for all implementers.
- Assess your team's internal capacity for filming the youth video. Does your team have the necessary skills, experience, availability, and equipment to produce and edit this video internally?
- If your team does not have this capacity internally, solicit proposals and quotations from relevant companies or organizations to produce the video.
- The final video, after editing, should be no more than 5-7 minutes.

TALKING POINTS FOR KEYNOTE/GUEST

Talking points for guest and/or keynote speakers should be developed in advance of the Summit event. The talking points for Summit will be specific to your context and the position and expertise of your selected speaker. The talking points below provide an example from the Beyond Bias project Summit event in Tanzania.

Keynote/Guest Speaker Talking Points, Tanzania Summit

1. Youth situation today: Teen pregnancy leads to deaths caused by unsafe abortion, early child bearing, and increased dependence rate.

- In 2013, Tanzanian women had just over one million unintended pregnancies, 39% of which ended in abortion. The vast majority of which were clandestine procedures that put women's well-being at risk. (Source = Guttmacher Institute, 2016)
- Addressing the unmet need for contraception will reduce the unintended pregnancy rate and thereby abortions and the deaths and injuries that often follow unsafe procedures.

2. Early pregnancy reduces opportunity for our youth, especially our young women.

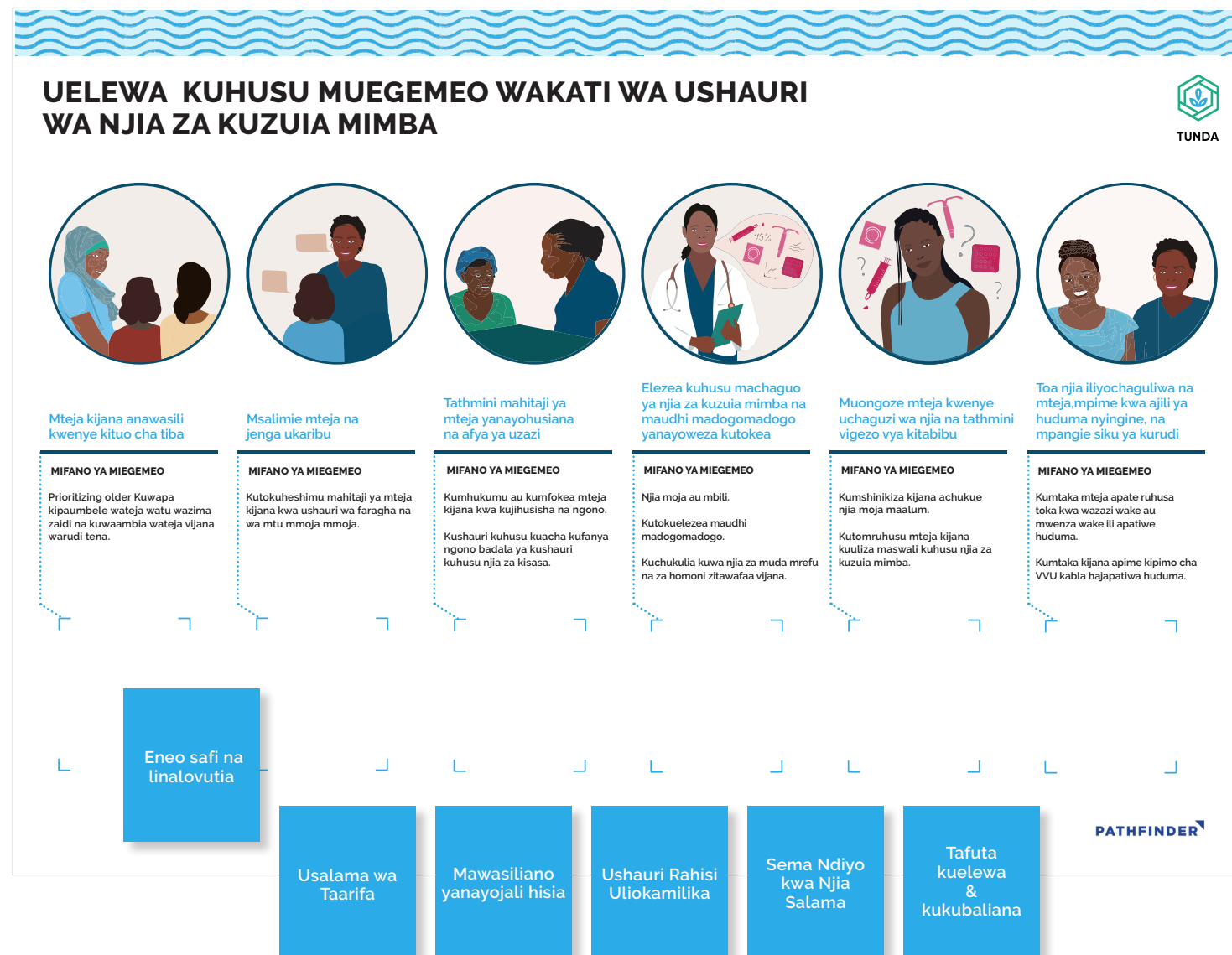
- Secondary school drop out for girls in TZ = 23%
- Among sexually active unmarried women age 15-29, 54% are using contraception; 46% are using a modern method (Source: DHS, 2016)
- Current contraceptive prevalence rate is 38%.
- TZ is aiming to reach 45% of married women of reproductive age by 2020.

3. Current Tanzania policies support all men and women to access complete FP services, regardless of marital status or parity. (Tanzania National Family Planning Guidelines and Standards, 2013)

- "All men and women including young people (10–24 years of age), irrespective of their parity and marital status, are eligible to access accurate and complete family planning information, education, and services."
- "Decisions about contraceptive use should only be made by the individual client."
- "No parental or spousal consent is needed for an individual to be given family planning information and services, regardless of age or marital status."
- "Before provision of a family planning method or methods, clients should be counseled on the range of available contraceptive options, and should be provided with accurate and complete information to enable them to make an informed decision."

ANNEX 4. Sample Connect Implementation Materials

CONSULTATION JOURNEY POSTER AND SIX PRINCIPLES STICKERS




ANNEX 4. Sample Connect Implementation Materials (cont.)

LEARNING REFLECTION CARDS


DATE: _____ La Récolte Module 1

Quelles sont deux actions que le groupe s'est engagé à prendre ensemble pour trouver une solution au préjugé envers les jeunes?

 BÂTIR L'AVENIR

Tarehe: _____ LA RECOLTE MODULI YA 1

Zipi ni hatua mbili ambazo kundi limeahidi kuzichukua kwa pamoja kushughulikia miegemeo kwa vijana?

 TUNOA

English translation: "What are two actions that the group has committed to take together to find a solution to bias against young people?"

METHOD CARDS



ANNEX 5. Sample Rewards Implementation Materials

REWARDS EVENT AGENDA

NAI UMANG REWARDS EVENT AGENDA		
Attendees: Beyond Bias Implementation Team, Providers		
TIME	ACTIVITY	SUPPORT ACTIVITY AND MATERIALS
5 min	Welcome	
10 min	Introduction of the meeting, ground rules	
10 min	What did we evaluate for Rewards?	
15 min	Overview of the performance results	
10 min	How to interpret your report cards	
15 min	Questions + Discussion	
20 min	Present awards to the qualifying clinics	Rewards Kit Envelopes
20 min	Feedback on Experience of Nai Umang Program to date (focus on Connect)	Take detailed notes for qualitative data
10 min	Next Steps in Nai Umang	
15 min	Questions	
	Closing of the ceremony	

Bâtir L'Avenir Rewards Ceremony and Quarterly Action Planning

This guide should be used by facility managers after the quarterly Rewards Event to conduct a meeting with their team of family planning providers.

Time : 45-60 minutes

Objectives

- Inform providers of how they are performing on the Six Principles of Unbiased Care, based on the data from clients.
- Celebrate providers for the areas that they are performing well in and achieving improvement upon.
- Collectively identify actions that can be taken as a team to improve services to young, unmarried clients over the next quarter.

Materials

- Report card
- Action planning card
- Rewards envelope with pins, certificates, and letter of congratulations (if your facility has been rewarded)
- Pens

Preparation before the session:

- Set up chairs in a circle where all providers can participate in the discussion.

Part 1: REWARDS

If your facility has qualified for Rewards this quarter, conduct a short celebration ceremony with your team of providers to recognize them for their hard work!

1. Welcome your team (2 min)

- a. SAY: "This is a ceremony to celebrate your hard work and excellent performance in delivering reproductive healthcare to all clients, regardless of clients' age, marital status, and parity."

2. Show the report card and explain the performance results (10 min)

- a. Read your Report Card aloud, and congratulate your team on their good performance.
- b. Pass around the report for everyone to see.

3. Present the Pins and Certificates (10 min)

- a. Open the Rewards Envelope and show them the Certificate of Achievement.
- b. One by one, ask your team members to come to the front of the room.
- c. Shake the hand of each provider and thank him or her.
- d. Take a reward pin from the Rewards Envelope and pin it on his or her uniform.

4. Invite participants to express appreciation for their colleagues (10 min)

- a. SAY: "Together, we have been recognized as a team. Does anyone have a short story to share about a time that you observed one of your colleagues providing excellent service to a young client? This is an opportunity to celebrate and appreciate each other."
- b. Invite participants to share stories of appreciation with each other.

5. Take a group photo to share! (1 min)

- a. Take a group photo with the certificates, and everyone wearing their pins.

Part 2: PERFORMANCE REVIEW AND ACTION PLANNING

1. Review your Report Card in detail with your team (10 min)

- a. What are the Principles that we are performing well on?
- b. What are the Principles that require improvement?
- c. Take time to explain the data and feedback to your team members. Invite them to ask questions and make sure that they understand the report card data.

2. Discuss the areas for improvement with your team (15 min)

- a. ASK: "Why do you think we are not doing as well as we could on these Principles?"
 - i. Invite participants to share their reflections.
- b. ASK: "What are specific actions that we could take individually and as a team to improve our performance on these principles?"
 - i. Write down ideas from participants and encourage everyone to share.

3. Commit to action (10 min)

- a. SAY: "These are all great ideas for how we can improve our services. Of the actions that we've discussed, what are 2-3 that we want to commit to as a team and focus on over the next three months?"
- b. SAY: "We will check in on our progress every month during our Connect sessions and address any challenges that arise."
- c. Write down the actions on the Action Planning Card and pin it up somewhere in the clinic where everyone will be able to see it.

4. Summarize next steps (2 min)

- a. Explain to your team that they will get another report card in three months and another opportunity to get rewarded for their performance.
- b. Thank everyone for their time, commitment, and attention.

5. Wrap-up and Data Capture for Facilitators (2 min)

1. Take a picture of the Action Planning card.
2. Share the picture of the card and any pictures you took during the group exercise on the Batir L'Avenir Leaders WhatsApp group.

Post-Activity Data Capture — Facility-Level Action Planning

1. Facility Name: _____ Date of activity: _____

2. How many participants did you have during the session? _____

FACILITY-LEVEL REPORT CARD

FACILITY PERFORMANCE REPORT

Clinic

Location

Date August - October 2019

Cohort 3



BATIR
L'AVENIR

Your Overall Score

72 /100

18 points to reach Model Unbiased Facility Status

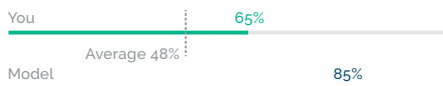
😊 Maintain Success!

😊 Making Progress

😞 Need Improvement

Your performance on the Six Principles of Unbiased Care

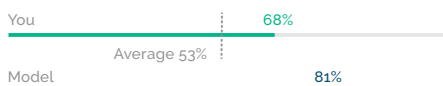
1. Safe Welcoming Space



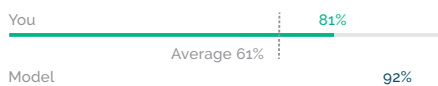
4. Say Yes to a Safe Method



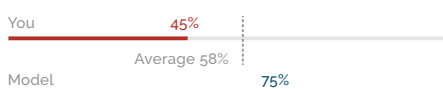
2. Sensitive Communication



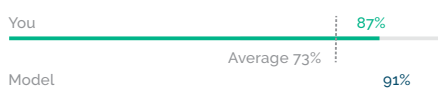
5. Seek Understanding & Agreement



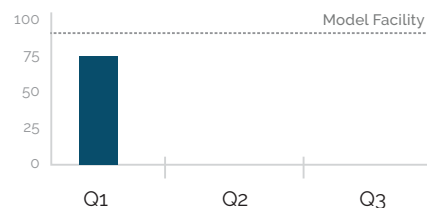
3. Simple, Comprehensive Counseling



6. Security of Information



Track your Progress



Tips for improvements

- 1 Counsel youth clients on a full-range of methods, including short-acting and long-acting methods. All modern methods are safe for youth.
- 2 Ask Clients about what method they prefer and guide them to a decision. Do not pressure clients to choose a particular method.

PATHFINDER

ANNEX 5. Sample Rewards Implementation Materials (cont.)

RECOGNIZING PROVIDER AND FACILITY PERFORMANCE

A key element of recognizing provider and facility performance is to provide trophies, sashes, or other forms of awards. You can choose any form of recognition that would be meaningful in your context.



ANNEX 5. Sample Rewards Implementation Materials (cont.)

REWARDS CEREMONY KIT



Rewards Envelope

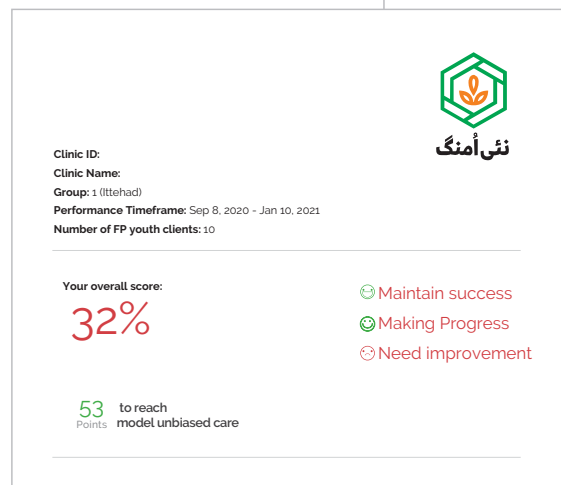
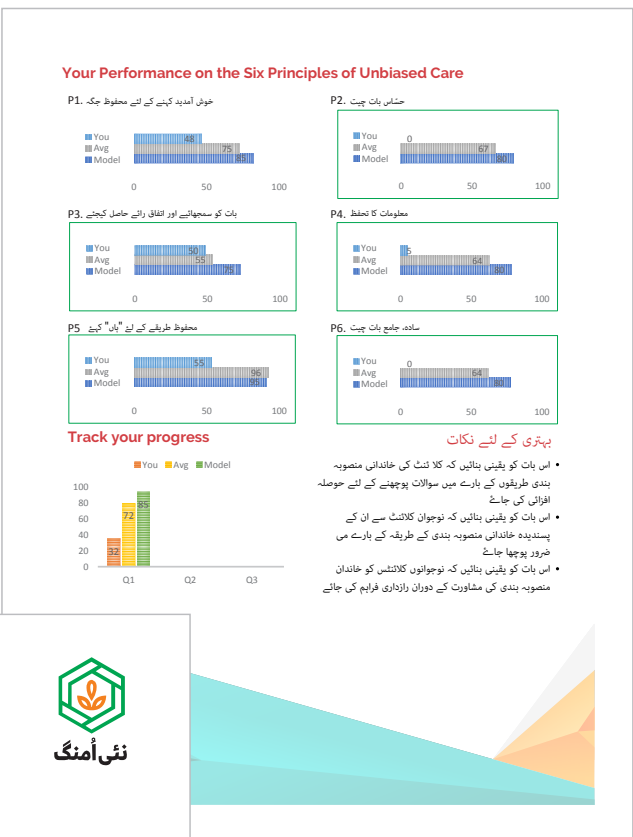


Example Merit Pin with Backing Card

English translation: "Together we are building a better future for young people."



Certificate of Achievement



ANNEX 6. Perceived Person-Centeredness of FP Care Tool

Beyond Bias Perceived Person Centeredness of Family Planning (PPCFP) Tool

HOW TO USE THE PPCFP TOOL

This 14-question survey instrument was designed to assess how well providers adhered to the principles of person-centeredness of FP care by measuring respondent's level of agreement to key statements based on their recent FP care experience. PPCFP scores can be calculated for overall performance (all 14 questions) or for specific domains or principles by averaging scores based on completed client surveys for that time period (quarterly, semi-annually, etc.).

Scale / Item No.	Item	MIN SCORE	MIN SCORE
Perceived Person-Centeredness of FP Care (PPCFP = MI + PI)		0	56
Domain 1: Person centeredness of Method Information (MI)		0	12
1	Did the provider ask you if you had any questions?	0	4
2	Were you told what to do if you experienced side effects or problems?	0	4
3	Did the provider give you information about what to do if you wanted to stop using a method?	0	4
Domain 2: Person centeredness of Provider Interaction (PI = VI + NVI + PDA)		0	44
Sub-Domain 2a: Person centeredness of Verbal Interaction (VI)		0	12
4	Did the provider you saw for family planning allow you to give your opinion about what you needed?	0	4
5	Did the provider you saw for family planning consider your personal situation when advising you about FP methods?	0	4
6	Did the provider you saw for family planning give you the time you needed to consider the contraceptive options they discussed?	0	4
Sub-Domain 2b: Person centeredness of Non-Verbal Interaction (NVI)		0	12
7	Did you feel the provider you saw for family planning cares about you as a person?	0	4
8	Did you feel like the provider you saw for family planning involved you in decisions about your FP choice?	0	4
9	Was the provider interested in your opinions?	0	4
Sub-Domain 2c: Perceived Disrespect and Abuse (PDA)		0	20
10	Did you feel the provider judged you?	0	4
11	Did you feel the provider scolded you?	0	4
12	Did the provider make you feel uncomfortable because of your sex life?	0	4
13	Did the provider pressure you to use the method they wanted you to use?	0	4
14	When meeting with the provider during your visit, do you think other clients could see you?	0	4

HOW IS EACH QUESTION SCORED?

For Domains 1, 2a and 2b:

0-Strongly Disagree;
1-Partially Disagree;
2-Neither Disagree nor Agree;
3-Partially Agree;
4-Strongly Agree

For Domain 2c:

5-Strongly Disagree;
4-Partially Disagree;
3-Neither Disagree Agree; 2-Partially Agree;
1-Strongly Agree

ANNEX 7. Additional Implementation Materials

Throughout the guide we have referenced a range of materials which can be instrumental to planning for, adapting, and implementing the Summit, Connect, and Rewards Pillars of the Beyond Bias model. Some of these materials, listed below, are lengthy and therefore can be accessed and downloaded separately through the Beyond Bias website:

<https://www.pathfinder.org/publications/beyond-bias-practical-how-to-guide/>

These materials include samples of:

Summit Facilitation Guide

Connect Intensive Phase Curriculum Modules

Connect Digital Moderator Guide

Digital Connect Content Plan

Digital Connect Digital Engagement Prompts and Modules

ANNEX 8. Supplemental Publications

Beyond Bias — Project Overview

<https://www.pathfinder.org/publications/beyond-bias/>

Beyond Bias Webinar: Combating Provider Bias Toward Young People

<https://drive.google.com/file/d/15LETq3nw7c9kyTzWHOxrwzLsrJXVcPL4/view>

Beyond Bias Segmentation

<https://www.pathfinder.org/publications/beyond-bias-segmentation/>

Beyond Bias Evaluation

<https://www.pathfinder.org/publications/addressing-provider-bias-in-contraceptive-service-delivery-for-youth-and-adolescents/>



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The Beyond Bias project sought to ensure that young people have access to empathetic, non-judgmental, high-quality counseling and provision of a full range of contraceptive methods regardless of their age, marital status, or parity. To achieve this, the Beyond Bias project worked to design and test innovative, scalable solutions that address harmful provider biases. Led by Pathfinder International, in collaboration with Camber Collective, YLabs, and RAND, this multi-year project was active in Burkina Faso, Pakistan, and Tanzania, with funding from the Bill & Melinda Gates Foundation.

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