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Addressing Provider Bias in Contraceptive Service Delivery for Youth and Adolescents: An Evaluation of the Beyond Bias Project

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SECTION I:

An Overview of the Beyond Bias Project



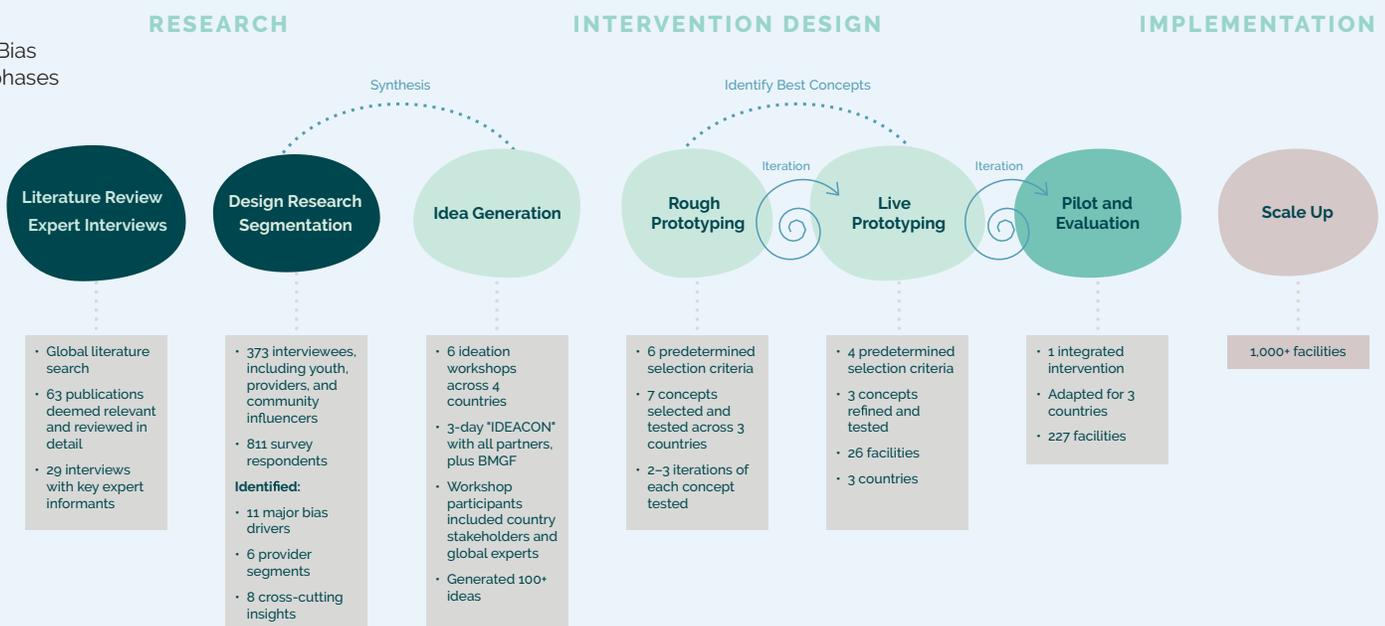
Introduction to Beyond Bias

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), market segmentation, behavioral economics, and social and behavior change (SBC) principles in designing and testing innovative, scalable solutions that address provider biases. FIGURE 1.

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 methodology.

FIGURE 1.
Beyond Bias
project phases



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, 23 million adolescent women aged 15–19 living in developing regions have an unmet need for modern contraception and are thus at elevated risk of unintended pregnancy.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

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 practical, 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 in Pakistan may be denied family planning services due to provider bias prioritizing bridal fertility, 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 Theory of Change

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

FIGURE 2.
Theory of Change



FIGURE 3.
Behavior Change Strategy



The Six Principles of Unbiased Care

The Six Principles of Unbiased Care, 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 4 .
Six Principles



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

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 encourage providers to own their biases



Individual action planning and public commitment to turn motivation into practice

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 that drive discussion with peers



Technical expertise and practical tips that dispel misinformation



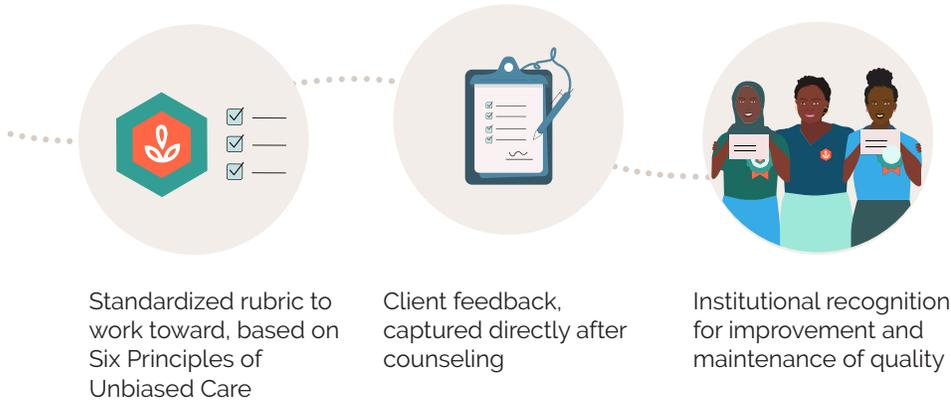
Safe space to share struggles and successes with peers



Regular review of unbiased service delivery goals

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.



Graphics: 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:
<p>SAFE, WELCOMING SPACE</p>	<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 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>
<p>SENSITIVE COMMUNICATION</p>	<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>
<p>SEEK UNDERSTANDING AND AGREEMENT</p>	<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

SECTION II: **Evaluation of the Beyond Bias Project**



Evaluation Main Outcomes of Interest

Evaluation of the Beyond Bias project was conducted using mixed-method analysis. Main outcome domains included:

(1) provider attitudes/beliefs; (2) patient-centered FP care; (3) FP method received; and (4) perceived treatment (FIGURE 5) and were measured using a mix of quantitative and qualitative methods. These domains were aligned with the Beyond Bias project's theory of change, which was that "if providers' biased attitudes and beliefs towards target groups (FP clients aged 15-24, unmarried, nulliparous, or any combination of these attributes) can be reduced, then more patient-centered FP care will be available to clients, clients will be more able to receive modern contraceptive methods of choice, and clients' perception of treatment received by the provider will improve". The evaluation analyzed all outcomes in accordance with this framework.

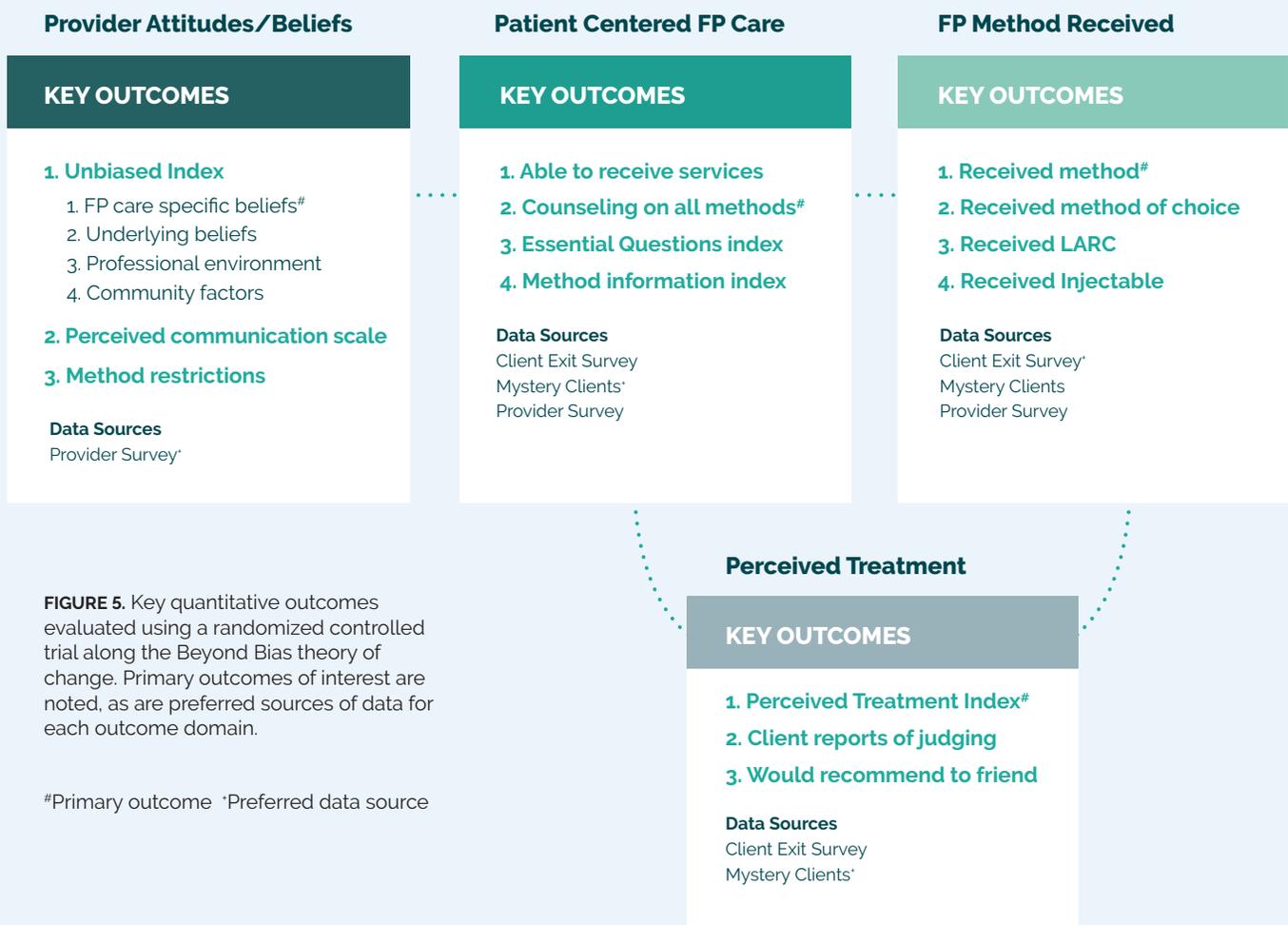


FIGURE 5. Key quantitative outcomes evaluated using a randomized controlled trial along the Beyond Bias theory of change. Primary outcomes of interest are noted, as are preferred sources of data for each outcome domain.

#Primary outcome *Preferred data source

Methods

STUDY SITES/SAMPLE SIZES

Sites selected for Beyond Bias project implementation were determined by country stakeholders including Ministries of Health, other implementing organizations, and donors. The Beyond Bias project did not have direct control over which sites were selected. For the evaluation, sites were enrolled as follows:

Tanzania: An initial 75 public sector clinics were enrolled in the study and randomized into the intervention arm (n=38) and control arm (n=37). Two facilities in the intervention group were later dropped (one because the army took over administration and the other because it ceased providing FP services).

Pakistan: Eighty private sector providers were recruited (40 intervention and 40 control). Nine providers dropped out of the study after a "COVID-19 pause" (see Timeline section below) (8 in control group, 1 in intervention group) and 5 were replaced because they dropped out prior to the refresher summit after the pandemic. Each new clinic was randomized to the treatment or control arm. The final sample had 76 providers, 41 intervention providers and 35 control providers.

Burkina Faso: 78 public sector facilities were enrolled in the study and randomized into the intervention arm (n=39) and control arm (n=39). All facilities took part in the study with no facility attrition.

SITE RANDOMIZATION

Randomization was conducted using Stata's RANDTREAT package. Random assignment was

conducted at the clinic level in Tanzania and Burkina Faso and at the provider level in Pakistan prior to the start of the intervention. Provider-level assignment was infeasible in Tanzania and Burkina Faso because the intervention was conducted at the clinic level. Clinics were not aware that they were being randomized for the intervention. In Pakistan, all clinics were operated by a single provider so provider and clinic level are the same. Randomization was stratified based on characteristics for which data was available at baseline including district, urban/non-urban setting, volume of clients under age 20, number of providers in the clinic, whether the provider was a midwife, and other factors.

EVALUATION TIMELINE

Implementation of Beyond Bias began in each of the three countries in late-2019/early-2020. In March 2020, a decision was made to halt project implementation due to the COVID-19 pandemic - this period, which went from March 2020 to August 2020, is referred to as the "COVID pause period". As shown in the table below, some monitoring data (e.g., facility service data and exit survey data) were collected throughout project implementation, while other data were collected specifically for end-of-project evaluation purposes during the project's final two months of implementation (e.g., mystery client data, provider survey data, and qualitative interview data). Results from the project's final 12 months (post-COVID pause) were the focus of this evaluation.

TABLE 1. Implementation and Evaluation Timeline

	2019				2020								2021																
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG					
TZ Intervention							COVID PAUSE PERIOD																						
PK Intervention							COVID PAUSE PERIOD																						
BF Intervention							COVID PAUSE PERIOD																						
Service Data																													
Exit Surveys							COVID PAUSE PERIOD																						
Mystery Clients							COVID PAUSE PERIOD																						
Provider Survey							COVID PAUSE PERIOD																						
Qualitative IDIs							COVID PAUSE PERIOD																						

For the purposes of the evaluation, we focus on the final 12 months after the COVID period.



ETHICS APPROVAL

Ethics approval to conduct this study was received from RAND's Human Subjects Protection Committee as well local ethics review boards in all three countries.

TOOLS

A wide variety of **quantitative and qualitative** tools was used to evaluate the Beyond Bias project. Quantitative tools included:

Client exit surveys: administered by youth enumerators (18-24 years old, chosen to make young clients more at ease), locally contracted by Beyond Bias. Data collection started ~5 weeks before the first Summit to provide a baseline. (Note: due to security and other logistical issues, baseline client exit data was not collected in Pakistan.) Enumerators were posted at facilities throughout the intervention, approached female clients upon their exit, and requested clients' verbal consent to conduct a survey about client's visit. If the client provided consent and reported that the reason for their visit was to receive FP or that they received FP counseling during the visit, the survey was administered. The survey collected information on basic demographics about the client (age, parity, and marital status), information on questions the provider asked and services offered, and the subjective experience of the client. Surveys were administered in local languages, offline, on a tablet, using Kobo Toolbox survey software. In treatment clinics, Beyond Bias used these surveys to calculate clinic scores used for the Rewards intervention.

Mystery client visits: A local survey firm was contracted to train young female enumerators to act as FP mystery clients based on eight client profiles developed by the Beyond Bias team. Client profiles included every combination of marital status (married/unmarried), parity (one child or no children), and age (16/17 or 24 years-old). Clients were also assigned to have a preference for either injectables or a long-acting method though only disclosed this preference if the provider asked. Each clinic in Tanzania and Burkina Faso received four anonymous visits while providers in Pakistan received only two visits since these were smaller, single-provider clinics and the team wanted to avoid raising suspicion. Within an hour of leaving the facility, mystery clients completed a debriefing survey administered by their supervisor. The survey recorded information on the quality of services they received, including methods the provider counseled on, whether they were made to feel comfortable, and whether the provider asked about their preferences. They also recorded whether they thought they could have received specific methods had they been a real client. All mystery clients were blinded to whether the facility was an intervention facility or a control facility.

Provider survey: Data was collected from providers using two instruments: a provider survey and a discrete choice experiment (DCE). The provider survey recorded information on (1) the providers' demographic characteristics and background information, (2) general attitudes and beliefs about young, unmarried, and nulliparous FP clients, and (3) details on the clinic environment where they practice, especially as they relate to youth and family planning services. The DCE elicited self-reported behavior around contraception service provision to women of different ages, marital statuses, and parities. It presented a hypothetical client, only telling the provider her age, marital status, and parity and then asked the provider to detail how they would provide services to this client (e.g., what methods they would counsel on). Surveys were administered to 642 providers across the three countries, from both intervention and control facilities.

Administrative service delivery data: Service delivery statistics are routinely collected by clinics in Tanzania and Burkina Faso as part of the Ministry of Health monitoring system. Data are added to a national database each month to which Beyond Bias had access. In Pakistan, service data are collected by Greenstar, a social marketing organization of which all enrolled clinics were a part. Relevant service delivery data included monthly number of new contraceptive users, returning contraceptive users, age categories of users, and method mix.

Cost data: Data on all costs related to Beyond Bias intervention implementation in each country were collected to support cost-effectiveness analysis. From this data, all costs related to research or international oversight (e.g., Pathfinder staff based in the US that would not be involved in a scaled-up version of the intervention) were then subtracted.

In addition to quantitative data, qualitative data was also collected. For client and provider interviews, a subset of all enrolled facilities was sampled (in Burkina Faso and Tanzania, 11 treatment and four control facilities; in Pakistan 22 treatment and eight control providers), selected based on facility characteristics, primarily stratified by region or district, and based on performance during the first and second Rewards stages (i.e., “high performing” versus “low performing”). All qualitative tools were tested prior to fielding. Interviews were conducted in local languages. Specific qualitative tools included:

Client in-depth interviews (IDI): In each country, ~70 youth clients seeking family planning services were recruited. Upon giving consent to be interviewed and recorded, clients were interviewed in a private location either within or near the facility. Clients received a small gift for participation. Client interview guides were semi-structured and aimed to capture the client's experience obtaining FP care at the facility and the providers' behavior with them during the visit. Interviews specifically probed the counseling received by the client, engagement of the client in choice of FP method (if one was received), and quality of provider engagement.

Provider IDIs: In each country, a total of ~30 intervention and control providers were interviewed using semi-structured in-depth interview guides. Interviews took place in person in a private location in the facility. The objective of the interview with control providers was to understand their attitudes, behaviors, and perceptions related to providing FP care, particularly for young women. The objective of the interview with intervention providers was to understand their impressions of the Beyond Bias program and if/how their service provision changed since participating.

Health facility manager IDIs: In Tanzania and Burkina Faso, five administrators from five intervention facilities were also selected to participate in semi-structured in-depth interviews. Facilities were selected to be representative of the sample as well as facilities that responded well and not as well to the intervention. The objective of the interviews was to understand managers' perceptions of the Beyond Bias program and the value it added for providers at their facility.

Stakeholder IDIs: In all three countries, members of Beyond Bias Advisory Committees were interviewed. Committees were made up of national and regional government officials, Beyond Bias staff, Pathfinder country technical directors, representatives from local non-governmental organizations and global organizations including United Nations agencies, local researchers, and local health care providers and administrators. In Pakistan, we also interviewed enumerators employed to collect client exit data from participating providers. Nine stakeholders in Tanzania, 16 stakeholders in Pakistan, and 13 stakeholders in Burkina Faso were interviewed over the phone or in person. Interviews focused on Beyond Bias implementation and the potential for expansion and scale-up of the model.



Quantitative Results

How did the Beyond Bias intervention impact provider attitudes and beliefs?

FIGURE 6 shows that the intervention reduced biased attitudes and beliefs with respect to age, marital status, and parity. Each point represents the (unadjusted) difference between intervention and control facilities in terms of standard deviations (positive means less biased) with 95% confidence intervals. Beyond Bias improved the unbiased index by about 0.7 standard deviations in the pooled analysis (analyzing data from all three countries together) and this effect size was similar across all countries. Most of the effect was driven by the “FP care specific attitudes and beliefs” (the pre-specified primary outcome for this domain) and underlying attitudes and beliefs about the target population. Attitudes and beliefs about the professional environment and community factors that could be drivers of bias improved slightly in Burkina Faso but not in the other countries (these types of beliefs were not explicitly targeted by the intervention).

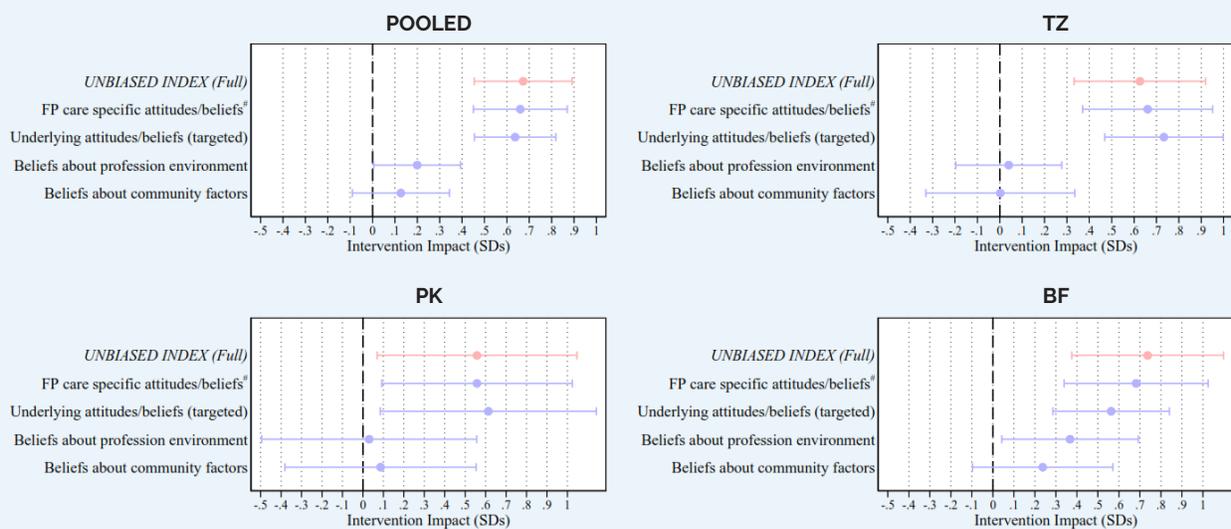


KEY TAKEAWAY

Providers at intervention clinics reported less biased attitudes and beliefs with respect to age, marital status, and parity in all three countries compared to providers at control clinics. Effects were most prominent for beliefs about how to provide FP care to these types of clients and underlying beliefs about the lives and intentions of these clients.

In terms of effect sizes, analysis of the proportion of providers that agreed with (or disagreed with for negatively framed questions) specific items making up the “FP care specific index” at intervention and control clinics showed significant improvements in 22 of the 27 items in the pooled analysis. For example, providers were significantly less likely to report imposing method restrictions because a client was “too young” (23 percentage point reduction), unmarried (7 percentage point reduction), or did not have children (15 percentage point reduction).

FIGURE 6. Bias indices from provider survey



Note: Positive means less bias

BIAS INDICES were created using the endline provider survey. Indices were created by taking the average of a standardized set of variables by country. Items that were negatively phrased were recoded so that higher values represented more supportive family planning attitudes.

How did the Beyond Bias intervention impact *primary client outcomes*?

FIGURE 7 summarizes findings for the three primary client outcomes (one per domain). The full set of outcomes for each domain are also presented in the following sections. The evaluation identified mixed results for the primary client outcomes: some outcomes improved for some data sources in some countries. In pooled analyses, counseling on the full range of methods improved according to all three data sources by varying magnitudes (e.g., a 6.5 percentage point improvement per mystery client data, the preferred data source, but which was only significant at the 10% level). The pooled analysis showed a 1.9 percentage point improvement in receiving a modern method per the client exit data (the preferred source), which was significant at the 10% level (driven entirely by Tanzania). The other two data sources also showed significant improvements

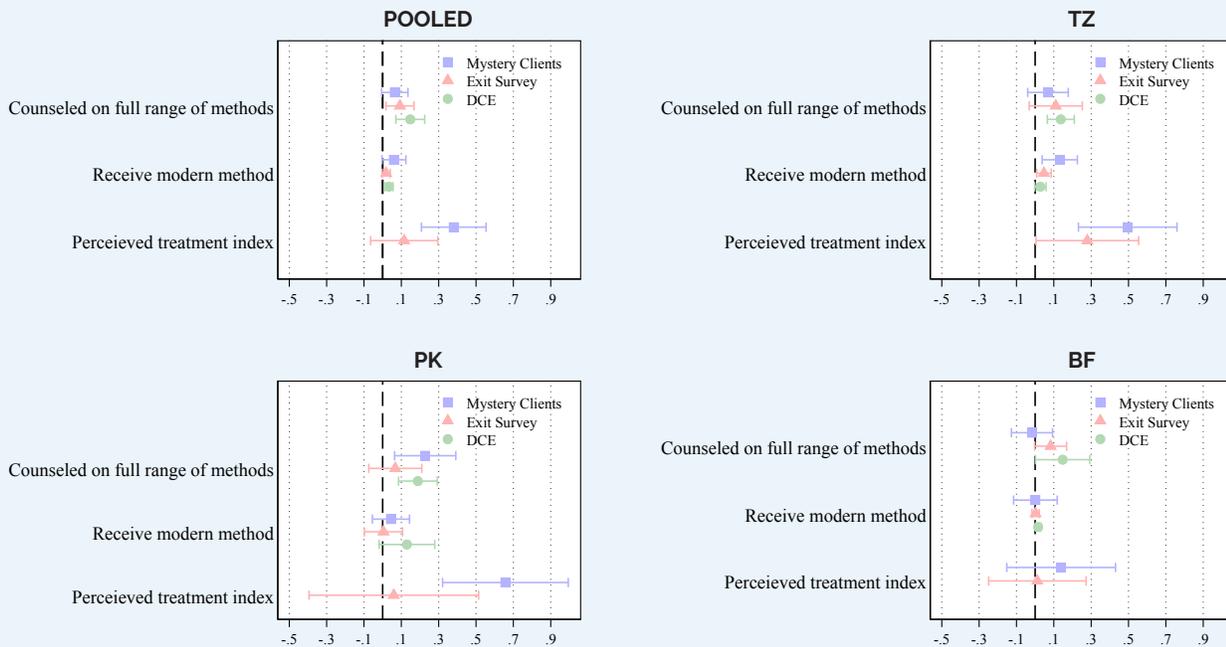


KEY TAKEAWAY

Beyond Bias improved several of the primary client outcomes, with the largest and most prominent improvements coming from the way clients were counseled and the way clients felt they were treated (particularly in Tanzania and Pakistan). Most clients in the control group received a method, so there was little room for improvement on this outcome. In Burkina Faso, there were no clear improvements for any of the primary client outcomes.

in modern method dispensing but these should be interpreted with caution given that no method was actually dispensed to mystery clients or in the DCE. The “perceived treatment index”, capturing the client’s report of how they felt and were treated during the visit, improved by about 0.4 standard deviations per the mystery client data (the preferred source) and about 0.1 standard deviations in the exit survey data, although the latter level of improvement was not statistically significant.

FIGURE 7. Impact of Beyond Bias intervention on primary client outcomes



OUTCOMES included in this figure were all pre-specified as primary outcomes. Control and intervention group means and confidence intervals estimated using linear regression with standard errors clustered at the facility. The discrete choice experiment is from the endline provider survey. Client exit data includes data collected from September 2020 to August 2021. Client exit data includes clients 24 or younger and includes data collected from September 2020 to August 2021.

In Tanzania (FIGURE 7, upper right panel), modest improvements were detected in counseling on the full range of methods (although only significant in the DCE); a 4.7 percentage point improvement in receiving a modern method per the exit survey data and improvements in the other two sources; and significant improvements in the “perceived treatment index” per both the mystery client data (the preferred source) and exit survey data. In Pakistan, significant improvements in counseling on a full range of methods and perceived treatment in the mystery client data (the preferred source for these outcomes) were observed, but not in the exit survey data. No significant effect was found on receiving a modern method in Pakistan according to any of the data sources. In Burkina Faso, the intervention had little effect on any of the primary client outcomes. The only outcome for which a significant effect was observed was counseling on a full range of methods, but this effect was close to zero in the preferred source (mystery clients).

How did the Beyond Bias intervention impact patient-centered FP care for women 15-24?

In terms of all patient-centered FP care outcomes, FIGURE 8 plots the intervention effect for each outcome. In pooled analyses, significant improvements are detected in all outcomes across all data sources, aside from receiving services in the mystery client data (almost all mystery clients received services so there was no scope for improvement). In the preferred data source for this domain (mystery clients), clients at intervention clinics were not only counseled on more methods than control clinics but were also more likely to be asked essential questions and were given more information about the methods. These positive effects in pooled analysis with the mystery client data were completely driven by Tanzania and Pakistan—effects were all close to zero in Burkina Faso in the mystery client data. In the exit survey data, all three countries had similar effects sizes for the four outcomes and all pooled effects were significant. In the DCE, intervention providers were more likely to report counseling on the full range of methods and were more likely to counsel on LARCs and injectables compared to providers in the control group.

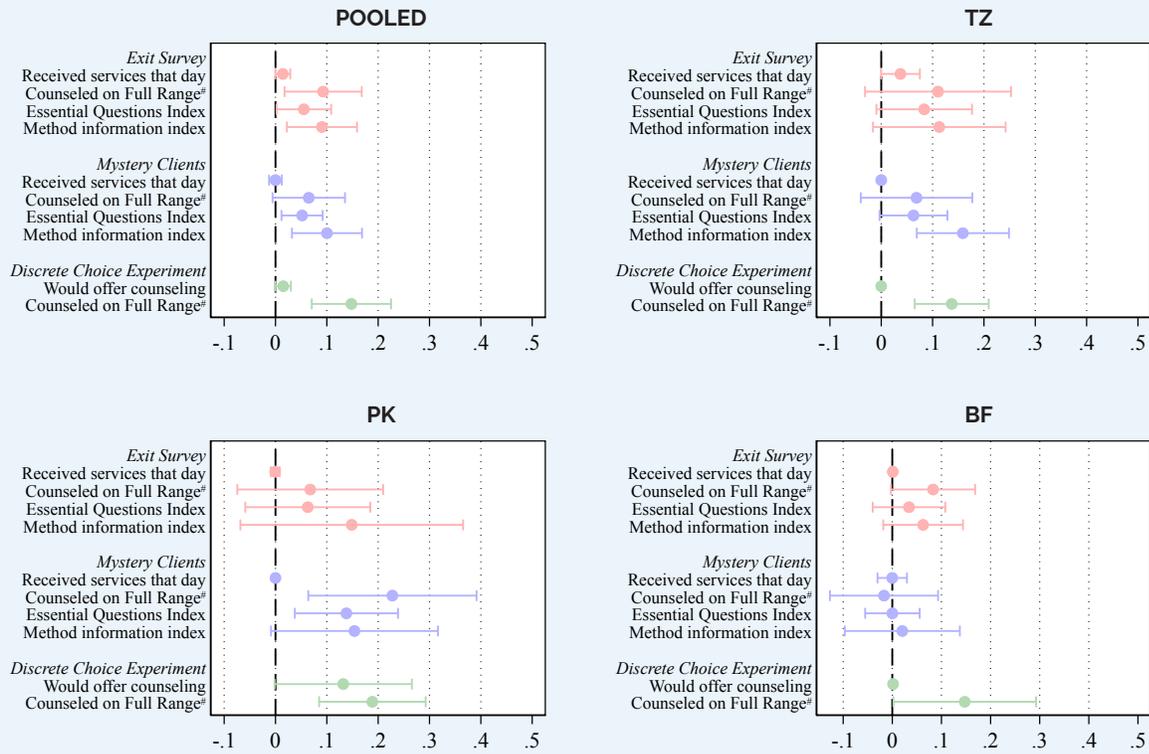


KEY TAKEAWAYS

Beyond Bias significantly improved all patient-centered FP care outcomes in all three data sources in pooled analyses. Improvements in Tanzania and Pakistan were consistent across data sources although not always statistically significant. In Burkina Faso, effects were not consistent across data sources and were close to zero in the mystery client data, the preferred source for this domain. Overall, this suggests that the intervention led to more comprehensive patient-centered counseling in Tanzania and Pakistan but it is unclear if it did so in Burkina Faso.



FIGURE 8. Impact of Beyond Bias intervention on patient-centered FP care outcomes.



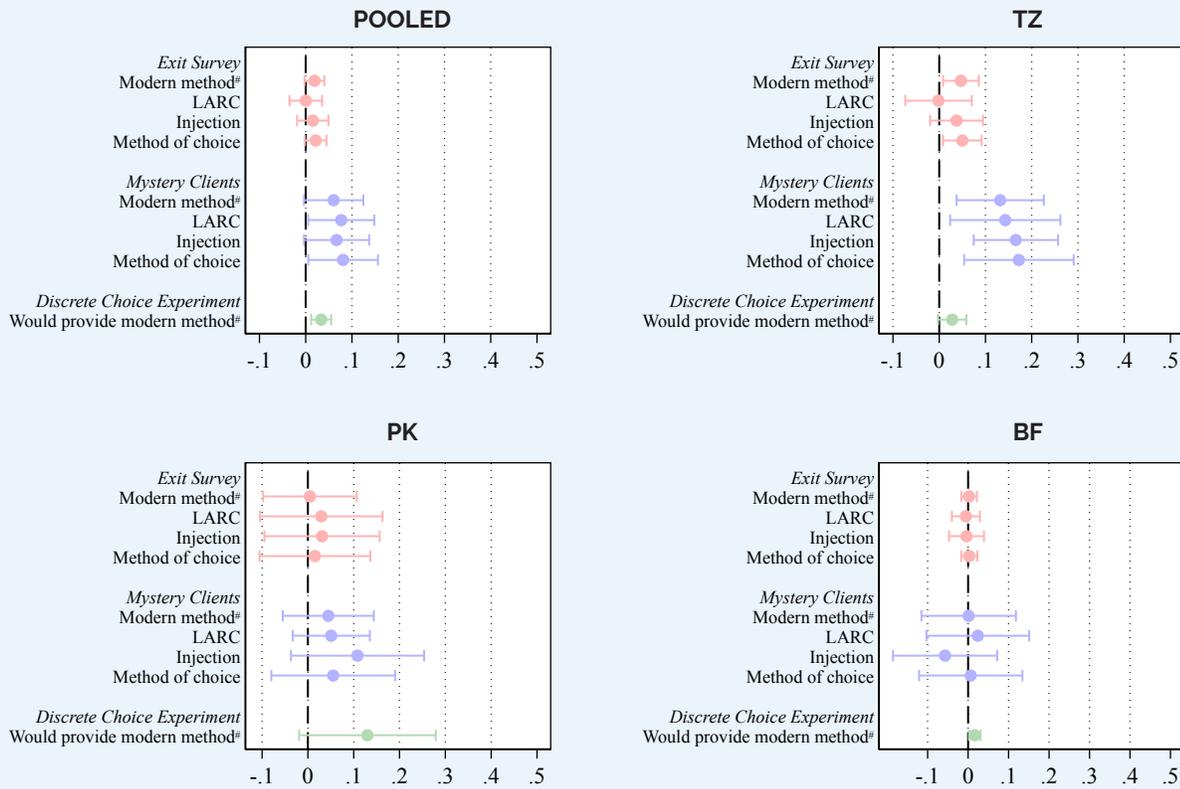
EACH POINT represents the difference between the intervention and control arm for the respective outcome. Error bars are 95% confidence intervals estimated with standard errors clustered by clinic. Pooled results control for country fixed effects. #=Primary outcome

How did the Beyond Bias intervention impact method dispensing for women 15-24?

As seen in Figure 9, over 91% of clients in the control group in Tanzania and Burkina Faso received a modern method, leaving very little room for improvement. In Pakistan, 82% of clients in the control group received a modern method.



FIGURE 9. Impact of Beyond Bias intervention on method dispensing outcomes



EACH POINT represents the difference between the intervention and control arm for the respective outcome. Error bars are 95% confidence intervals estimated with standard errors clustered by clinic. Pooled results control for country fixed effects. #=Primary outcome

Tanzania was the only country in which modern method dispensing improved in the exit survey data (the intervention increased the share of clients that received a method by 4.7 percentage points ($p < 0.05$)). About 9% of clients in the control arm did not receive a method in Tanzania, so this effect size represents a nearly 50% reduction in the share of women not receiving a method. Five percent more women received their method choice in the intervention arm compared to the control arm, but this was driven by more women receiving any method at all (there was no change in method of choice among women receiving a method). These results are almost entirely driven by fewer women being denied services. If a woman was not able to receive services, we coded this as not receiving a modern method and not receiving method of choice.



KEY TAKEAWAYS

Most clients in the control group reported receiving a method and their method of choice in the exit survey, particularly in Tanzania and Burkina Faso. Thus, there was little room for improvement on these outcomes. The intervention improved the likelihood of receiving a method and receiving method of choice in Tanzania, but effect sizes were small. There was no effect on receiving a method or method of choice in Pakistan or Burkina Faso in the exit survey. There was also no effect on method mix in any of the countries, suggesting that providers did not change the types of methods they dispensed. Mystery clients were more likely to think they could take their method of choice at intervention clinics in Tanzania and intervention providers in all three countries were more likely to report a modern method as appropriate in the DCE, which is promising, but no methods were actually dispensed in either of these data sources.

A 3.7 percentage point increase in receiving any services was observed in the intervention group in Tanzania. When we restrict to clients who received services, we do not observe a significant improvement in these outcomes. This suggests that the intervention in Tanzania did not improve modern method uptake or method of choice among clients who saw a provider, but rather influenced the likelihood clients were able to see a provider. The intervention had no effect on method dispensing or on receiving method of choice in Pakistan and Burkina Faso. No evidence was found that clients were more likely to receive LARCs or injectables in any of the three countries, two methods for which biased attitudes and beliefs were identified in the formative work.

For method dispensing outcomes, mystery clients reported whether they “thought they could take” any method “if they were a real client”. All pooled effects for method dispensing outcomes in the mystery client data were significant and, similar to exit survey data, these pooled effects were mostly driven by improvements in Tanzania. Mystery clients visiting intervention clinics in Tanzania were far more

likely to think they could take each method (13 percentage points) and their method of choice (17 percentage points). In Pakistan, the intervention demonstrated positive effects on method dispensing according to mystery client perceptions but none of these effects were statistically significant. In Burkina Faso, the intervention had no effect on mystery client perceptions of which methods they could take.

In terms of method mix, little evidence was found that the intervention impacted method mix in any country. Analysis of the proportion of clients that received each method based on exit surveys indicate that method shares were comparable between intervention and control sites for all age groups, with no statistical differences. In addition, service delivery data from all three countries showed that method mix did not change over time between intervention and control clinics in any country. Evaluation results show that intervention clinics dispensed roughly the same share of each method in all study months relative to control sites.





KEY TAKEAWAYS

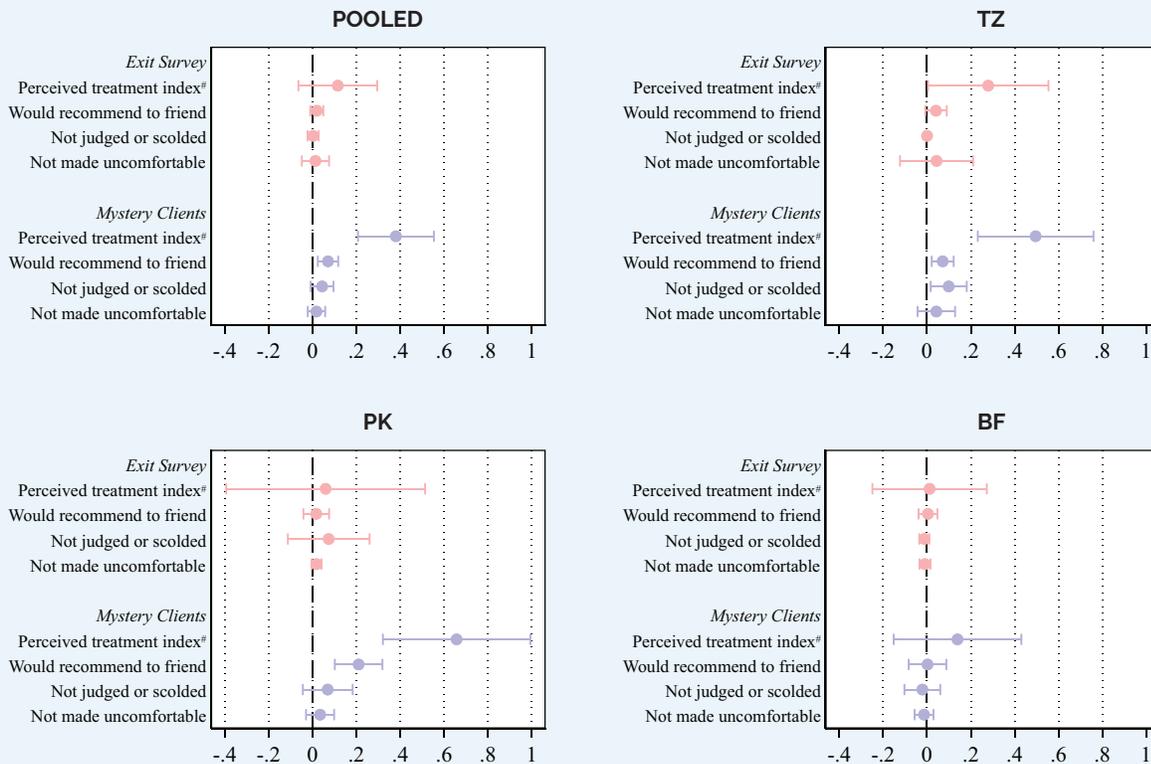
The intervention improved mystery client perceptions of how they were treated by providers. Significant effects with countries pooled were mostly driven by improvements in Tanzania and Pakistan, with small and insignificant effects in Burkina Faso. Only in Tanzania did real clients perceive better treatment from the provider.

How did the Beyond Bias intervention impact perceived treatment by FP providers for women 15-24?

As shown in **FIGURE 10**, mystery clients in intervention sites reported better treatment on the “perceived treatment index” and the perceived communication scale, and were more likely to recommend the clinic to a friend compared to control sites. Positive, significant pooled effects were driven by improvement in Tanzania and Pakistan, with little change in Burkina Faso on these outcomes. In Tanzania, mystery clients who visited intervention facilities were 7 percentage points more likely to recommend the clinics to a friend and 9 percentage points more likely to report not being judged or scolded by the provider (a 50% reduction in the

likelihood of being judged or scolded). In Pakistan, mystery clients who visited intervention providers were 21 percentage points more likely to recommend intervention providers to a friend and 7 percentage points more likely to not be judged or scolded compared to control providers, although the latter was not statistically significant. Mystery clients in Tanzania and Pakistan were also less likely to report being treated worse based on marital status or parity.

FIGURE 10. Impact of Beyond Bias intervention on perceived treatment outcomes



EACH POINT represents the difference between the intervention and control arm for the respective outcome. Error bars are 95% confidence intervals estimated with standard errors clustered by clinic. Pooled results control for country fixed effects. #Primary outcome

How did the Beyond Bias intervention impact *monthly client volume*?

The average number of clients per month over the 12 months of intervention did not appear to increase at intervention sites for any age group in Burkina Faso or Tanzania. In Pakistan, there appeared to have been a modest but statistically significant increase in client flow, which was mostly driven by clients under 20 years old (about 2 additional youth clients per month per clinic). Youth client volumes did not increase over time at intervention facilities (even in Pakistan), which is what one would expect if word was getting out about improvements in care and treatment of young clients. Taken together, there is little evidence that the intervention increased client volume in Burkina Faso and Tanzania, but may have increased youth client volume in Pakistan.

Did the intervention reduce *disparities in outcomes by age, marital status, and parity*?

The intervention mostly did not change the effect of age, marital status, and parity on the main outcomes of interest. Evaluation measures showed only limited effects of age, marital status, and parity in absence of the intervention, suggesting that outcomes that improved as a result of the intervention did so for all clients, not just clients targeted by the intervention. It also suggests that Beyond Bias clinics were not the best settings for

targeting disparities experienced by youth clients, unmarried clients, and nulliparous clients. For example:

Age disparities: Most differences between older and younger women were relatively small and the intervention did not significantly change the extent to which age affected any outcomes.

Marital status disparities: Differences between unmarried and married women were smaller than expected or non-existent for most outcomes in the control group and the intervention did not significantly change the extent to which marital status impacted any Beyond Bias outcomes.

Parity disparities: Nulliparous mystery clients were less likely than parous mystery clients to be counseled on the full range of methods (all three countries), real nulliparous clients were less likely to receive a LARC (Tanzania only), and the intervention significantly reduced both of these disparities. However, this result was not consistent across the other data sources. Differences between nulliparous and parous clients in most other outcomes were relatively minor, leaving little room for improvement, and the intervention did not significantly reduce the effect of parity on any other outcomes.

Intersectionality: We had limited statistical power to assess intersection of age, marital status, and parity due to small sample sizes for some specific combinations. In Tanzania and Pakistan however, married women who do not have children appeared to receive the worst care on average, regardless of their age, and intervention impacts were particularly large for these profiles. In Burkina Faso, there were not any clear patterns of disparities or intervention impacts for specific client attribute combinations.

Qualitative Results

Burkina Faso

Qualitative findings in Burkina Faso mostly support the quantitative results. Providers reported changes in their attitudes and beliefs in response to the intervention; providers at both intervention and control facilities mostly did not report giving biased care; and it was rare for clients to perceive receiving biased care. Some providers and clients reported differential treatment based on age although most did not, which is consistent with quantitative findings (differential treatment was reported in the mystery client data but was rare). There were some reports of different types of methods encouraged to different types of clients and specific types of service refusal (e.g., based on menstrual cycle); although this was consistent with the quantitative data, these reports were relatively uncommon.

There were also two areas of note from qualitative findings that did not emerge in the quantitative findings. First, providers reported in qualitative interviews changing the way they counseled to include more methods, but this was not observed through mystery client data (we do observe a small improvement in counseling on the full range in the client exit and DCE data). Second, qualitative interviews added nuance about potential intersectionality in bias that was not picked up by quantitative analysis, for example bias against married and nulliparous clients and clients who are students (still completing their studies).



KEY TAKEAWAYS

Providers in Burkina Faso enjoyed participating in the intervention and found implementation smooth although faced some structural challenges (space constraints, commodity stockouts). Summit was viewed as informational and awareness-raising. Connect allowed focused time to discuss improving FP service provision for youth, Rewards was (mostly) motivational—and many providers discussed how their knowledge and attitudes were changed by the intervention. Providers at higher-performing intervention facilities (top-performing facilities based on Rewards scores in Q1 and Q2 or those with large increases in Rewards scores from Q1 to Q2) more commonly discussed specific ways that their counseling behavior has changed (e.g.,

offering a wider range of methods, stopping service refusals), and new structural/operational changes like a youth-only space and expanded operating hours to better meet young people's needs, compared to providers at lower-performing intervention facilities (those with low scores either in Quarter 1 or that saw a large drop in rewards scores between Q1 and Q2). Policy and program stakeholders reflected positively to the idea of scaling up the initiative and felt that integration/institutionalization would be the best and most sustainable strategy. Concerns about scaling up included resistance from communities and uncertainty about whether this is a high-priority area for decision-makers.

Pakistan

Qualitative results support quantitative evidence of attitudinal changes among providers following participation in Beyond Bias. Intervention providers reported being more open to serving unmarried women and nulliparous married women and influencing their understanding of IUDs. Qualitative findings also contrasted with quantitative findings in several ways. First, some providers reported changing behaviors as a result of the intervention so as to not limit or refuse services to certain types of clients, particularly unmarried clients. This does not show up in the quantitative data partly because we have very few unmarried clients in the exit surveys and the mystery client unmarried profile was designed to be as socially acceptable as possible. As with client exit data, qualitative data cannot speak directly to bias experienced by unmarried

women, and to a lesser extent nulliparous women, because very few interviews were conducted among women with these characteristics. Second, there were several anecdotes of bias (or expectations of bias) for young women, unmarried women, and nulliparous women that do not show up prominently in the quantitative data. This result is not necessarily inconsistent with quantitative findings; rather, qualitative findings demonstrate that these biases exist but quantitative findings indicate that they are not as common as expected. Qualitative findings also suggest that intervention providers perceived an increase in the number of clients seeking family planning services.



KEY TAKEAWAYS

Beyond Bias interventions were well-received by providers in Pakistan, although many faced challenges in participating with Connect. Providers cited ways in which their knowledge increased due to participating in the intervention (including appropriate use of IUDs), and how they have modified their approach to FP counseling including ensuring privacy and focusing on informed choice as well as fewer service refusals. Some higher-performing providers also mentioned that participating in Beyond Bias gave them courage to resist social norms about FP use. Respondents appreciated how participating in Beyond Bias connected them to a community of like-minded FP providers. Both providers and program and policy stakeholders were positive about the idea of scaling up the intervention (some said

that their enthusiasm depends on the evaluation results); concerns included resource needs and whether there would be the necessary level of buy-in and engagement of different stakeholders. Some providers shared how participating in Beyond Bias increased their responsibilities or added new challenges, though most found the activities well-integrated into their existing duties. Lastly, some providers at both intervention and control facilities shared persisting biased attitudes and behavior, including refusing services to certain women for religious or other social reasons. However, clients expressed a high degree of satisfaction with their FP care, though several felt that women with particular attributes (young, nulliparous, unmarried) would (hypothetically) be treated worse.

Tanzania

While qualitative data documented instances of bias towards young women, several instances of better treatment for young women were also reported which is consistent with findings from the quantitative data. Qualitative interviews with managers and providers supported changes in service provision reflected in client exit data. Providers highlighted that they started serving additional young clients by prioritizing young clients when they entered the facility. Interviews with

control providers and clients served at control facilities supported evidence of potentially biased care for married nulliparous women, which is consistent with the intersectionality analysis of specific mystery client profiles. Qualitative data also showed that providers in both intervention and control sites tended to have preferred methods they encouraged clients to use, results supported in analyses of non-registered outcomes in the mystery client data.



KEY TAKEAWAYS

Providers in Tanzania were very positive about Beyond Bias. Summit was lauded as a unique, impactful and enjoyable experience; providers liked learning from their peers at other facilities via Connect (WhatsApp); and Rewards was motivating both to those who did and did not receive an award. Many providers spoke about changes to their knowledge and attitudes about FP for young people, and several shared poignant anecdotes to illustrate these changes. Some facilities also made workflow changes, e.g., prioritizing young clients for faster services and offering new youth-friendly operating hours. Providers mentioned systemic implementation challenges, including space constraints (more common at lower-performing intervention sites) and staff shortages (more common at higher-performing intervention sites). At a higher level, program and policy

stakeholders mentioned some implementation challenges including the mix and engagement of partners. There was widespread enthusiasm among providers, managers, and stakeholders about taking Beyond Bias to scale but several recommended that this should be done by the government as an institutionalized/integrated service and following engagement of diverse stakeholders from youth, civil society, several Ministries, and community groups. Providers at control sites, and clients at both intervention and control sites, shared numerous examples of biased FP services, particularly aimed at young people (encouraging particular methods that would cause a quicker return to fertility), married women (needing partner permission), and nulliparous women (expectation that those who are married should begin childbearing).



Cost Analysis

To conduct a cost analysis, all expenditures put towards the Beyond Bias project were extracted from internal project records. Data were used to estimate the cost of implementing the intervention during the 12-month pilot phase plus one month of preparation to set up the project. Costs were grouped into several categories:

- **Labor costs were based on monthly salaries of local staff.**
- **Materials and resources included things like printing, fuel, building fees, and vehicle fees.**
- **Intervention activities include all non-labor costs that were specific to each intervention pillar.**

Youth enumerator payments were included as part of the Rewards intervention.

Connect and Summit intervention costs were combined because these were challenging for the in-country staff to separate.

Total number of intervention clinics in each country was used to estimate cost per clinic; the total number of providers at intervention facilities was used to estimate cost per provider; and the total number of clients who visited intervention facilities over this period was used to estimate cost per client exposed.

Over the 12-month period, intervention clinics served 95,003 clients in Tanzania, 10,472 clients in Pakistan, and 50,533 clients in Burkina Faso.

TABLE 2 details costs for each category, total costs, and costs per clinic/provider/client for each country. Note that all costs associated with international staff and research during this pilot phase were excluded because these costs would not be incurred if the intervention were scaled-up.



KEY TAKEAWAYS

Running the Beyond Bias intervention for 12 months cost \$5,444 per clinic, \$1,352 per provider, and \$2.12 per client exposed in Tanzania. In Pakistan, it cost \$3,531 per clinic/provider and \$13.83 per client exposed. In Burkina Faso, it cost \$5,972 per clinic, \$523 per provider, and \$4.61 per client exposed. In terms of cost per person exposed and cost per provider, this puts Beyond Bias near the upper end of FP-focused social and behavioral change interventions. For example, a recent USAID-sponsored report⁴ found that 12 provider training interventions cost \$397/provider on average, with the most expensive costing \$2,467/provider. Strategic changes in Beyond Bias' implementation approach however - for example developing a shorter client-facing survey that could be integrated into existing data collection systems - could reduce costs of the model significantly.

⁴ Avenir Health. 2021. "Documenting the costs of social behavior change interventions for health in low- and middle-income countries," Breakthrough RESEARCH Technical Report. Washington, DC: Population Council.

TABLE 2. Cost of implementing the Beyond Bias project for 12 months (2021 USD)
TZ=Tanzania, PK=Pakistan, BF=Burkina Faso

	TZ		PK		BF	
	COST	%	COST	%	COST	%
Labor	\$94,328	47%	\$52,874	37%	\$63,520	27%
Materials and Resources	\$31,444	16%	\$21,156	15%	\$15,170	7%
Intervention Activities	\$75,641	38%	\$70,754	49%	\$154,237	66%
Rewards	\$58,017	29%	\$69,288	48%	\$114,386	49%
Summit and Connect	\$17,624	9%	\$1,466	1%	\$39,851	17%
Total	\$201,413		\$144,784		\$232,927	
<i>Cost per clinic</i>	\$5,444		\$3,531		\$5,972	
<i>Cost per provider</i>	\$1,352		\$3,531		\$523	
<i>Cost per client exposed</i>	\$2.12		\$13.83		\$4.61	
Total (w/o enumerators)	\$159,573		\$80,850		\$150,634	
<i>Cost per clinic (w/o enumerators)</i>	\$4,313		\$1,972		\$3,862	
<i>Cost per provider (w/o enumerators)</i>	\$1,071		\$1,972		\$339	
<i>Cost per client exposed (w/o enumerators)</i>	\$1.68		\$7.72		\$2.98	

Costs exclude international staff and research activities. Total number of clients exposed is based on number of clients attending intervention clinics over the 12-month study period; 95,003 in Tanzania, 10,472 in Pakistan, and 50,533 in Burkina Faso.

The Connect and Summit interventions were relatively inexpensive aside from the labor needed to organize the events. Summit and Connect were more costly in Tanzania and Burkina Faso than in Pakistan because in the former countries, Connect featured an in-person component whereas in Pakistan, Connect was done entirely through WhatsApp. The Rewards intervention was by far the costliest of the three interventions, accounting for about a third of total costs in Tanzania and nearly half of total costs in Pakistan and Burkina Faso. Note however that, while the Rewards intervention was

resource-intensive during this pilot phase, this was due to deliberate design decisions made by the implementation team to allocate resources to paid youth enumerators who were essential for the overall project evaluation effort but not meant to be part of the scalable version of the Beyond Bias design. A lower bound of what costs would look like with a less expensive data collection modality is included in **TABLE 2**. Exclusion of youth enumerator costs would reduce the cost per clinic by 21% in Tanzania, 44% in Pakistan, and 35% in Burkina Faso.



Discussion

The Beyond Bias project set out to design and implement an intervention to help “ensure that young people have access to empathetic, nonjudgmental, quality counseling and provision of a full range of contraceptive methods regardless of their marital status or parity”.

It appears that the intervention helped move closer to achieving this objective. The Beyond Bias intervention caused providers to report more empathetic, non-biased attitudes towards the target groups, to counsel young clients on the full range of methods more frequently, and improved young clients' perceptions of how they were treated during FP visits. However, the intervention mostly did not reduce the extent to which age, marital status, and parity affect the quality of counseling or the types of contraceptive methods offered. Nor did it lead to an increase in uptake of an expanded range of contraceptive methods for adolescents and youth who came into the clinic.

The lack of change in the influence of client attributes and methods received does not necessarily mean that the intervention was not successful. We find little evidence that age, marital status, and parity had a large effect on counseling, method uptake, or methods received in absence of the intervention, so there was never a real chance to reduce the effect of these client characteristics. This suggests that any intervention that targets women who are already coming into FP clinics in our study setting is unlikely to lead to a large reduction in disparities by age, marital status, and parity that have been observed at the population level. Moreover, most women in the control group received a method and reported that it was their method of choice, so there was also limited room for (measurable) improvement.

Although we do not find important improvements in method uptake, methods received, or disparities, this does not mean that the intervention does not have the potential to improve these outcomes. First, in a setting where disparities in care for the target groups are large, this intervention could be effective at reducing these disparities. However, exit survey results from five other countries⁵ also show little evidence of such disparities, so it is unclear how common these are. Second, the improved attitudes and beliefs, counseling quality, and client experiences from Beyond Bias could cause more young women to come into the clinic, and receive better care when they do. These target populations account for a very small portion of the client population (e.g., only 8% percent of clients were age 15-19 and only 6% did not have a child; less than 1 percent of clients were unmarried in Pakistan). This could be because they are worried about poor treatment or judgement from providers. A recent study from Senegal⁶ shows that women avoid clinics where there is greater provider bias. Some women might avoid clinics altogether if they do not

know of a clinic where they could get unbiased care. We do not find any evidence of increased client volume resulting from the intervention, but this could be because clients were not aware of the improved treatment and counseling they would receive. For example, during qualitative interviews in both Pakistan and Tanzania, providers reported no longer restricting care and turning away certain women (e.g., unmarried or very young women) after participating in the intervention; however, if few women with these attributes visit the facilities due to anticipated poor treatment, the potential for improved behavior is not observed in our client exit data. Over time, more women who avoided coming to FP clinics in absence of the intervention because they knew they would receive bias care could start visiting the clinic, thus reducing disparities in modern contraception use. Future work should explore coupling the Beyond Bias model with outreach efforts to inform the community about clinics that have less biased care (e.g., by making Rewards scores public).

How do we reconcile the fact that (1) we observe biased attitudes and beliefs of providers with respect to age, marital status, and parity in provider surveys and qualitative interviews in the control group, and (2) disparities in modern contraception use for young women are well documented in the literature, but (3) we do not observe large disparities in care or methods received based on age, marital status, and parity among clients visiting control clinics? First, this could be because the subset of young/unmarried/nulliparous women who come into the clinic are those that are the most determined to get the methods they want and the information they need to make their decision. They might also have private information that we do not observe in the data that makes their situation more socially acceptable or that leads them to experience less bias (e.g., they know the provider from elsewhere or they expect the provider will be sympathetic to their specific situation). Women who avoid the clinic might do so because they know they would experience biased care and be denied their preferred method. Thus, reducing disparities in modern contraception use for young women might



⁵ Speizer, Ilene S and Lisa M Calhoun. 2020. "Examination of Bias Across Client Exit Interview Data Sources. Full Access Full Choice Technical Report."

⁶ Speizer, Ilene S; David K Guilkey, Jennifer Winston and Lisa M Calhoun. 2021. "Does provider bias affect choice of a facility for family planning services by women in urban Senegal?" Studies in family planning.

require an additional focus on young women who choose not to come into the clinic. Second, providers might have biased attitudes and beliefs but still follow their training and best practices when counseling and dispensing methods. Thus, these biases might not pass through to client outcomes. Over half of providers in the control group had already received training on youth friendly services, which might partly explain why we do not observe disparities for young women in our setting even in the presence of attitudinal bias. Third, some of our qualitative data indicate that reports of biased attitudes/beliefs and discrimination against young women often refer to very young women (i.e., under age 15). Our mystery clients were 16 or older and almost no exit surveys were conducted with women 15 or younger. Thus, it is entirely possible that women 15 or younger receive biased care or are denied services, and that outcomes for these women would be better at intervention clinics, but we do not capture this information in our data.

In addition, qualitative interviews from Burkina Faso and Tanzania revealed that some intervention clinics extended their hours to serve youth during off-hours. As exit surveys were only conducted during normal clinic hours, we may have missed visits from youth most likely to experience bias. Similarly, in Pakistan, our unmarried mystery clients were design to be as socially acceptable as possible out of concerns of extremely poor treatment or danger. In other words, this was the unmarried profile that was least likely to experience bias.

Another anomaly from our analysis is that we document important improvements in the information given to clients (e.g., more counseling on the full range of methods) but we do not observe a change in methods received. If clients were not receiving their method of (informed) choice in absence of the intervention, we would expect counseling on a larger range of methods to change the method they choose. There are two potential explanations for why we see improved counseling but no change in method mix. First, most women could already be receiving their method of informed choice, so more information does not change their choice. Second, intervention providers might



provide more method information than control providers but still encourage the same set of methods as control providers. This is supported by data analyzed in this evaluation, which shows that a large portion of providers encouraged one specific method for mystery clients (60% in Tanzania, 40% in Pakistan, and 30% in Burkina Faso) and the intervention did not have much of an effect on which methods were encouraged. They also discouraged methods at a similar rate. This is also supported by the interview data; for example, in Tanzania where providers expressed strong opinions about which methods are appropriate (generally discouraging injections and pills and encouraging IUDs and implants) and clients likewise reported being steered toward certain methods. Thus, intervention providers might counsel on an implant and an injection but encourage the implant and discourage the injection, whereas control providers only counsel on the implant and omit the injection. Both scenarios would result in the client taking an implant.

⁷ Solo, Julie and Mario Festin. 2019. "Provider bias in family planning services: a review of its meaning and manifestations." *Global Health: Science and Practice*, 7(3), 371-85.

One key challenge with provider bias research outlined by Solo and Festin⁷ is to estimate how provider bias affects client outcomes. This study is uniquely positioned to explore these pathways because the intervention induced an exogenous change in provider attitudes and beliefs, which are the foundation of bias, through randomization of the intervention. We find that reducing the extent to which attitudes and beliefs exhibit bias can lead to measurable changes in the way providers counsel and interact with clients. However, provider bias does not appear to be strongly associated with the FP methods received by clients.

One promising result is that mystery clients perceived a significantly greater likelihood of taking their method choice when visiting intervention clinics. This effect was particularly strong in Tanzania, which is also the only country where we observe an improvement in these outcomes in the exit survey data. It is not clear exactly how to interpret this and it is likely a combination of several different aspects of the visit rather than just method dispensing. But clearly mystery clients in Tanzania (and Pakistan to a lesser extent) thought they had access to an expanded range of methods in

intervention clinics compared to control clinics. Mystery clients were also assigned a method preference (IUD/implant or injectable) and they were more likely to think they could take their preferred method at intervention clinics. Real clients might not have a clear sense of what their preferred method is, so they might report receiving their method of choice even when there were other methods that better suited them (most women think they got their method of choice). In contrast, evaluators knew exactly what the "preferred method" for mystery clients was.

The Beyond Bias team expected from the outset of this project that the intersection of age, marital status, and parity would be an important predictor of provider bias (e.g., that parity is particularly important if a woman is married or that marital status is particularly important if a woman is young). While we had limited ability to explore this in the quantitative data (see limitations section), qualitative interviews supported this concept and suggested that intersectionality goes beyond just age, marital status, and parity. People embody multiple identities at once, and qualitative interviews indicate that providers may treat clients differently based not



only on their age but also, for example, whether they are a young person who is in school (and therefore have a "promising future" and may be more "deserving" of family planning so they can achieve their goals) or an out-of-school young person (who is perceived to have fewer life prospects and therefore may not "need" family planning as she will soon marry and begin childbearing). This concept of intersectionality also may influence which method(s) are encouraged, as the qualitative results from providers and clients suggest that students are perceived as "too busy" to come back often and therefore need longer-term methods. Additionally, especially in Burkina Faso and Tanzania, the overlay with the HIV crisis is worth noting: many providers felt that it is important to counsel young people in particular on barrier methods as they are perceived to be at higher risk for HIV and sexually transmitted infections. Whether this risk is viewed as heterogeneous, and whether and how this affects choice of FP methods—for example whether young people are taking up dual methods—are important areas for further study.

Evaluation results in Tanzania were most promising. This is the only country where we see significant improvements in every outcome domain, and effects were mostly consistent across data sources. Engagement with the intervention was very strong, and it seemed to be well-received per qualitative results: very few providers interviewed expressed challenges with engaging in the intervention and it was common for interviewees to share anecdotes that contrasted their prior attitudes and behavior to their current approach particularly toward young people.

In Pakistan, the intervention showed promise, but engagement was much lower than in Tanzania, effects were not as consistent across data sources, and there was no impact on method dispensing. More intervention engagement could have led to larger effects. There were also many implementation challenges such as refusal to participate and provider attrition. Of note, a majority of providers interviewed mentioned that they had challenges with Connect (technological barriers, not enough time to engage fully, and being annoyed by the frequency of contact), and Rewards was not

received as positively as in other countries. This suggests that private providers operating their own practice will be more challenging than larger public clinics to keep engaged with the various intervention components. Although there were positive aspects of the intervention that may have been uniquely beneficial to solo providers—especially the connections with other providers working in this space both through Connect and Rewards—the particulars of designing an implementation strategy that works for solo providers need to be carefully considered. There may also be gendered differences in ability to engage with the intervention particularly at single-provider facilities—for example if female solo providers also have less off-hours time to participate in Connect due to household duties (which we did not explore here but merit further study).

Burkina Faso showed similar improvements in provider attitudes and beliefs as Tanzania and Pakistan, but we do not see improvements in care quality and perceived treatment in Burkina Faso. One potential explanation for this is that providers already had relatively unbiased attitudes and beliefs in the control arm. Control arm providers in Burkina Faso were more likely to agree/disagree with statements that indicated less bias (e.g., 94% of control providers in Burkina Faso agreed that they would provide FP to a client that they thought was too young compared to only 63% in Tanzania and 56% in Pakistan). In addition, qualitative interviews with providers and clients in Burkina Faso yielded fewer insights about biased care, at either treatment or control facilities. Thus, biased attitudes and beliefs may have been less of a problem in Burkina Faso prior to the intervention. This is consistent with a recent qualitative study which found "overwhelmingly that providers are happy to give contraception to young, unmarried, and nulliparous women".⁸ Another explanation is that providers in Burkina Faso engaged less with the intervention; only 65% of providers we surveyed in the intervention arm in Burkina Faso reported attending the Summit (compared to over 80% in the other two countries)⁹, so it is possible they were less exposed to behavior change content.

⁸ Senderowicz, Leigh. 2019. "I was obligated to accept": A qualitative exploration of contraceptive coercion." *Social science & medicine*, 239, 112531.

⁹ Low summit attendance in Burkina is partly driven by a sizable proportion (~16%) of providers who had recently joined the clinic (i.e., worked in the clinic <12 months). Removing "new" providers from this analysis, exposure to Summit attendance increases to 77% in Burkina Faso.

The Burkina Faso qualitative interviews also revealed systemic issues that could not be addressed by the intervention, such as providers being very busy, not having enough space to provide privacy, and having method supply issues. Policy and program stakeholders also spoke about the importance of institutionalization and integration—ideally within government structures and activities—for effective scale-up and sustainability, and encouragingly this is already underway.

Different treatment effects experienced by different countries could be related to different levels of exposure to the intervention pre-pandemic (five months in Pakistan, three months in Tanzania, and one month in Burkina Faso). However, examination of treatment effects over time does not show a clear pattern of larger improvements as time passes, so, though it is not clear that differences in pre-pandemic exposure were important, they cannot be ruled out either.

Findings from qualitative interviews with providers are largely consistent with quantitative findings in terms of how providers said their behavior and practices changed in response to the intervention. However, the qualitative data revealed specific instances of provider bias towards the target groups—both in intervention and control sites—in all 3 countries, which might appear to conflict with quantitative data where we found that biases are not very frequent and that age, marital status, and parity do not have strong effects on care received or perceived treatment by the provider. This discrepancy may be because qualitative interviews go deeper into specific interactions which could reveal examples and memories of bias that we did not capture in the cross-sectional, immediate-recall quantitative data. Providers could also recall instances of bias for very young client (e.g. 15 or under), which we do not capture in our quantitative data. There is ample room to improve measurement of bias and future work should build off the learnings from this project. However, many of the biases we document in the qualitative section are detected by the exit surveys and by mystery clients (e.g., whether they were treated poorly because of age), and it is important to not interpret the

qualitative data as a measure of frequency of biased interactions. The qualitative interviews were designed to provide more detail and depth to experiences of bias, whereas the quantitative data document the extent of the problem. It is thus not clear that there is discordance between the qualitative reports of bias and the quantitative estimates of the extent of bias. The qualitative interviews revealed details on specific instances of bias and the quantitative data revealed that these instances were relatively rare (although they did happen) and did not lead to large disparities for the target groups.

In all three countries, policy and program stakeholders were largely enthusiastic about the intervention and encouraging about the prospect of scaling up or introducing Beyond Bias interventions in new countries. The most common concerns were about social/community norms in scale-up areas and stakeholders suggested needs analyses and community-based sensitization activities alongside scale-up. Additionally, it was common for stakeholders in all countries to reflect on how the government should be involved; integration with ongoing services was seen as essential for scale-up and sustainability, but stakeholders wondered if there was sufficient priority and “political will” to achieve this. Stakeholders were also optimistic about the impact that Beyond Bias has had but several said they were waiting on these evaluation results before making strong recommendations about continuation or scale-up.

The qualitative analysis also highlighted potential ways for improving the effectiveness of the intervention. Some providers suggested that they did not fully understand the Rewards scoring system and thus did not know how to change their behavior to improve their score, which was discouraging. Making the scoring system more transparent and linked to specific behaviors could help guide providers' behavior change strategies to increase their score. Finding ways of keeping providers engaged and carving out time in busy schedules is another area where effectiveness could be enhanced.

Limitations

This work should be interpreted in light of its limitations, of which there are several.

First, provider bias is an abstract concept that manifests in many different ways by different providers and is experienced differently by different types of clients. Measuring and quantifying provider bias is, thus, very challenging and there are likely aspects of bias that we did not pick up with our quantitative survey instruments (e.g., bias based on whether a young client is a student). Future work should build on measures created for this project to refine the science of measuring bias at FP clinics.

Second, a key goal of the Beyond Bias project and the FP community at large is to ensure that all clients receive their method of informed choice regardless of age, marital status, and parity. Measuring whether someone received their method of choice is very challenging because (1) clients could over-report receiving their method of choice due to social desirability bias and (2) clients might not be aware of what their method of informed choice is if the provider does not appropriately inform them about all methods. These factors may partly explain why very high rates of "method of choice received" were detected in client exit data (over 90% in Burkina Faso and Tanzania), while at the same time a large portion of mystery client visits recorded that they did not think they could have taken their method of choice (method of choice was assigned to mystery clients by the study team). Future work should focus on validating a measure to assess whether clients received their method of informed choice.

Third, it was known from the outset that the intersection of multiple client characteristics was important in terms of type and intensity of provider bias received (e.g., that parity would be more important for married women and that marital status would be more important for younger women). However, there are a large number of subgroups that could be created when examining intersectionality and evaluators did not have sufficient statistical power to fully explore the interaction of different client characteristics. Mystery client samples included only 40 visits per profile (20

in each arm) and some profiles were extremely rare in client exit data (e.g., married + nulliparous clients accounted for less than 1% the data). Thus the ability to draw conclusions about which combinations of characteristics were associated with the most biased care and which profiles benefitted most from the intervention was limited. Future studies would benefit from a larger sample of mystery client visits such that analyses of more intersectional combinations is feasible.

Fourth, the provider survey, the client exit survey, and the qualitative interviews relied on self-reports which are susceptible to social desirability bias. Providers, especially in the intervention group, could have overstated positive attitudes and beliefs about the target group because the Beyond Bias team trained them on what the "right" answer was. Similarly, clients could understate the degree to which they perceived poor treatment from providers because they did not want to make the provider look bad. Mystery clients largely address this issue but they have other weakness, such as not actually taking a method and potentially having different experiences than real clients.

Fifth, baseline data was lacking for many of the outcomes assessed. Although random assignment of the intervention ensures that outcomes and potential confounding factors are balanced at baseline on average, it is possible that chance imbalance on some characteristics could have biased estimates in unpredictable ways.

Sixth, while themes that emerged in interviews between control and intervention sites were compared, a larger number of clients and providers from intervention facilities were interviewed than in control sites. This limited the ability to have captured as much variation in experiences in the control sites.

Finally, it was not possible to assess the effects of this intervention at the community level and thus effects of Beyond Bias on community perceptions of provider bias or unmet need for FP were not assessed. Future work should explore community-level impacts of the Beyond Bias model.



Photo Credits: Pathfinder International – Burkina Faso, Pakistan, Tanzania. All photos feature participating providers at Beyond Bias Summit, Connect, and Rewards events or at the health facilities where they work.

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For the full evaluation report, please visit the Beyond Bias website: <https://www.pathfinder.org/projects/beyond-bias>

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