Integrating Human-Centered Design in a Multidisciplinary Effort to Address Provider Bias: The Beyond Bias Experience

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Part 3 of 3

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Introduction

The Beyond Bias project seeks to ensure that young people between 15 and 24 years of age have access to empathetic, non-judgmental, quality counseling and provision of a full range of contraceptive methods, regardless of their marital status or parity. By bringing together providers and the young people they serve, Beyond Bias works to design and test scalable solutions that address provider bias and improve contraceptive counseling and services. Led by Pathfinder International, Beyond Bias partners include Camber Collective, YLabs, and the Behavioral Economics in Reproductive Health Initiative (BERI). Beyond Bias is active in Pakistan, Tanzania, and Burkina Faso, with funding from the Bill & Melinda Gates Foundation (BMGF). Beyond Bias is innovative in its multidisciplinary approach, which brings together experts in adolescent and youth sexual reproductive health (AYSRH), social and behavior change communication (SBCC), human-centered design (HCD), behavioral economics, and segmentation analysis.[1] These complementary approaches enable a nuanced understanding of the drivers, manifestations, and outcomes of provider bias and inform tailored interventions to address that bias.

Despite increasingly frequent application of HCD in global health programs, there is limited published material on the process of doing so. Aiming to help expand that knowledge base, the Beyond Bias project has documented, in a three-part series, its experience using HCD as part of a multidisciplinary approach to develop effective and scalable AYSRH interventions: (1) The executive summary* provides high-level overviews of HCD and how it was applied in Beyond Bias, key lessons learned from the integration of HCD in Beyond Bias, and AYSRH solutions generated and tested by the project. (2) Part 2* of this series, "Application of Human-Centered Design in Beyond Bias," further describes how Beyond Bias integrated HCD and how that experience fits in the larger HCD ecosystem and details the project's key lessons learned from applying HCD. (3) This piece documents the SRH/AYSRH interventions that Beyond Bias is currently implementing as well as those that did not advance to the pilot phase, sharing key insights, ideas, and solutions that informed those interventions. While not all promising solutions that emerged from the design phase would work within the parameters of Beyond Bias (e.g., project timeframe, budget, and feasibility of measuring in the planned randomized control trial [RCT]), AYSRH programmers may want to consider them for other programming.

"If you don't meet youth in family planning, you meet them in labor."

— Nurse participant in Beyond Bias prototyping, Tanzania

* To download the executive summary, visit: https://www.pathfinder.org/publications/hcd-part-1-executive-summary/; to download part 2: https://www.pathfinder.org/publications/hcd-part-2-application/

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What Is HCD?

HCD is a creative, iterative, and participatory innovation process. Like participatory action research, and drawing on ethnographic research principles, HCD seeks to engage participants in the design, development, and testing of potential solutions. It relies on real-world prototyping of these solutions and rapid iteration based on participant feedback.
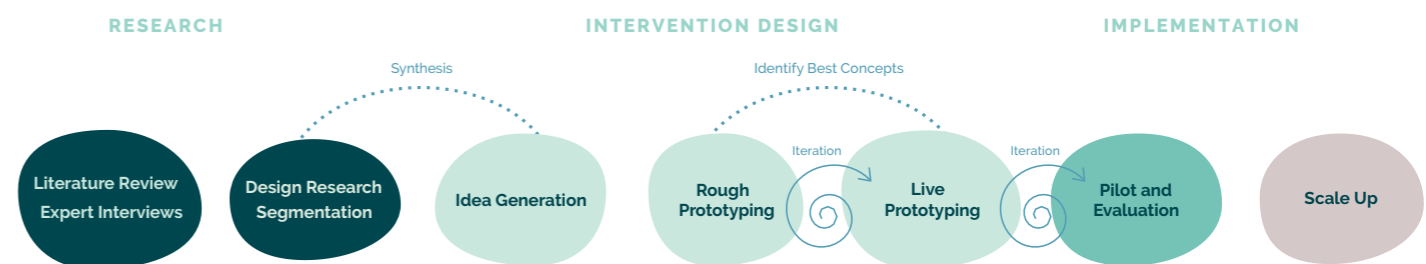
HCD emphasizes a process of rapidly generating and then testing a range of ideas to answer, with minimal material and monetary investment, essential questions about a potential solution's desirability and feasibility. HCD aligns with conventional wisdom in global health about the importance of interventions tailored to different contexts and target populations, and meaningful stakeholder engagement to ensure sustainability. While standardized and well-established in industries such as ergonomics and consumer technology, HCD is relatively new in global health, and its application varies widely among projects, implementers, and donors.

HCD in Beyond Bias: An Integrated Process

To address the enduring challenges of provider bias in provision of AYSRH, Beyond Bias employed a rigorous, multidisciplinary approach that included an intensive HCD process for intervention design (Figure 1). At the time of this writing, Beyond Bias is piloting an integrated solution, after which the project will evaluate the solution in an RCT and document and disseminate findings in a separate brief.

Beyond Bias began with expert interviews and a literature review of evidence on provider bias and past interventions to reduce such bias. This foundational evidence informed the creation of a quantitative segmentation survey. In parallel, Beyond Bias conducted qualitative design research interviews in each country. Based on qualitative and quantitative data analyses, Beyond Bias distilled key insights about provider and youth behavior and motivation. Using provider segments, drivers of bias, and qualitative findings, Beyond Bias country teams and partners facilitated structured ideation workshops to generate and prioritize ideas for interventions that could address provider bias in AYSRH services. Through a rigorous, multi-stage process, Beyond Bias partners, providers, and youth selected promising ideas for further development, prototyping, testing, and iteration. These findings informed the final intervention design and implementation. This overall approach and the HCD process are detailed in Part 2. At the time of this writing, Beyond Bias is piloting interventions, after which the project will evaluate their effectiveness in a randomized control trial (RCT) and document and disseminate findings in a separate brief.

Figure 1. Beyond Bias's Integrated Process for Addressing Provider Bias in AYSRH

RESEARCH | INTERVENTION DESIGN | IMPLEMENTATION

Literature Review / Expert Interviews → Synthesis → Design Research / Segmentation → Idea Generation → Rough Prototyping → Iteration → Live Prototyping → Identify Best Concepts → Iteration → Pilot and Evaluation → Scale Up

Key Insights into Provider Bias Toward Young, Unmarried Clients

In HCD, insights are realizations supported by qualitative data from the foundational design research phase. Insights provide a new perspective on the users (in this case, providers and youth) and their environment. They can shed new light on an old problem or bring clarity to a past interpretation of the problem or existing solution.

Insights typically go beyond characterizing the challenge (describing the "what") and bring to light why the challenge is occurring or persisting. Insights highlight the opportunities that exist for intervention. Beyond Bias gathered key insights about provider and youth behavior and provider bias—particularly towards young, unmarried, and nulliparous clients—during the project's design research phase. The project revised and refined these insights after the rough prototyping process.

1 **Bias is layered, intersectional, and (importantly) malleable.** It is not just about a client's age, marital status, or parity. There are modifiable factors—such as a client's word choice or confidence—in the mental heuristics that providers unconsciously and consciously use to profile clients.

2 **Time pressure fuels providers' implicit, split-second judgements about the needs of youth clients.** Youth clients yearn for more time to ask questions, but institutional pressure to serve more clients in a day exacerbates providers' tendencies to jump to conclusions about what methods (if any) a young client should have.

3 **Wanting what's "best" for a young person can be a driver of bias.** Providers see themselves as protectors of youth. When they send young patients away, recommend abstinence, or refuse to give modern methods, these actions often come from a place of concern and care, not from emotional disconnection.

4 **Providers have one foot in the community and one foot in the clinic.** Providers are struggling to reconcile professional norms with social norms that prohibit sex before marriage or expect young women to prove fertility soon after marriage. Their values often conflict with their training.

5 **Providers want to feel like (and be seen as) the expert and decider.** For providers, being the expert means making the method decision. In a job where they often feel overworked and underpaid, providers feel satisfied and respected when the patient accepts their method recommendation without question.

6 **Even when given choices about methods, youth are unprepared to weigh the choices.** Providers are trained to offer choices, but many youth clients expect the provider to make the decision for them.

7 **Friendly providers may be rated highly by youth even if the provider does not offer them a choice of methods.** From the perspective of young patients, more choice does not necessarily mean better quality service.

8 **Providers do not have dedicated time and space to discuss the emotional and clinical challenges that arise from working with youth clients.** With a large caseload and exposure to challenging human situations each day, many providers become too desensitized to cope.

Photo: YLabs, with written consent from participants

Intervention Design

Using provider segments, drivers of bias, and qualitative findings, Beyond Bias country teams and partners facilitated six structured ideation workshops across four countries (Tanzania, Pakistan, Burkina Faso, and the United States) to generate early brainstorming ideas for addressing provider bias.

Using provider segments, drivers of bias, and qualitative findings, Beyond Bias country teams and partners facilitated six structured ideation workshops across four countries (Tanzania, Pakistan, Burkina Faso, and the United States) to generate early brainstorming ideas for addressing provider bias. Brainstorm participants included clinical managers, providers, and youth. The workshops consisted of multiple rounds of brainstorming, using "How might we…?" statements. Each ideation workshop was guided by three overarching design prompts:

At the end of each workshop, the participants selected their top five ideas using a predetermined set of criteria; in total, these 30 ideas advanced to the next round of ideation (dubbed "IDEACON"). All Beyond Bias partners, including BMGF, convened for **IDEACON,** a three-day, in-person workshop at which each country team presented their top ideas, and attendees participated in additional rounds of brainstorming to combine earlier ideas and to identify new ideas. The ideation workshops and IDEACON generated more than 100 nascent ideas for addressing provider bias in AYSRH services.

How might we help providers guide informed contraceptive choice by youth?

How might we support providers to have the time and space to honor young people's needs in the clinic?

How might we measure and reward quality service for youth?

Since it can be impractical to empirically vet all initial brainstorming ideas (100+ in Beyond Bias), idea selection in the HCD process relies on the internal heuristics and expertise of the participants. This is one reason why it is valuable to have a diverse set of perspectives involved in idea generation, and why it is crucial that every participant is deeply familiar with the insights and evidence produced from the research phase. In Beyond Bias, the following types of expertise were represented: AYSRH, behavioral economics, SBCC, design, country-level clinical implementation, and the lived experience of youth and providers.

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Intervention Design

Figure 2. The Evolution of Beyond Bias Ideas, Concepts, and Solutions*

Overview of the Idea Generation and Solution Development Process

(Ideas/concepts **in bold** advanced to the next round, sometimes with new names, as noted in parentheses.)

TOP IDEAS (GENERATED BY ALL PARTNERS)			CONCEPTS TESTED IN ROUGH PROTOTYPING	CONCEPTS COMBINED INTO EVOLVED SOLUTION PROTOTYPE
Interactive Narratives	**Provider Forum**	**SeenDoing Well**	**Provider Forum**	
Story Clinic (Nuture)	**Bypass the Biases**	Silent Disco Booth	**Nuture**	
Digital Self-Assess	**Youth Bill of Rights**	Texting for Quality	**SeenDoing Well**	
Insta-rating	Plan Well Parties	Carrot & Stick	**Bypas the Biases**	
Participatory Theater	Ladies Night	Wifi Hotspots	Youth Bill of Rights	
School Visits	Find Your Way		Interactive Narratives	
Youth App	Auntie-Uncle Cool		Virtual Youth Clinic (previously "Digital Self Assessment")	

SUMMIT

CONNECT

REWARDS

Integrated Solution, adapted by country

* This document uses the word idea to describe a simple headline thought and the word concept for a more fleshed-out idea that includes a preliminary behavior-change hypothesis and a set of articulated assumptions that can be tested with users through prototyping. Concepts are tested and refined (and sometimes combined) into solutions.

Concepts Selected for Rough and Live Prototyping

The following concepts advanced to rough prototyping in 2017 (provider-facing) and 2018 (youth-facing).[1] The project conducted rough prototyping rapidly and sequentially across the three countries, as two-week sessions in each geography.

Data-informed iteration is a core part of the HCD process, and each rough prototype went through two or three iterations based on user feedback. After rough prototyping, the Beyond Bias team analyzed the qualitative data for all rough prototyping sessions to identify which concepts seemed promising in terms of predetermined criteria. Pathfinder's Technical Review Board further ensured that the recommendations were grounded in evidence and best practice. (The criteria and the Technical Review Board are discussed in Part 2*.) The Beyond Bias team combined complementary concepts based on their strengths, resulting in three refined concepts to move forward into live prototyping (denoted by ⏵ in the next section).

Provider-Facing Concepts

Interactive Narratives: In this "choose your own adventure" experience, providers take on the role of a young client, make decisions as the client, and see different possible endings to the story based on their decisions. The underlying assumption is that, stepping into the role of a young person can give the provider insights into a young person's thoughts, feelings, and needs, and into how a provider's actions can impact a young person's life.

⏵ **Nurture / Summit:** This story-sharing platform allows providers to hear real testimonies from youth, community members, and other providers. The underlying assumption is that clients' stories help cultivate empathy for youth among providers. Likewise, stories from community members and other providers can reassure providers that they have community support to provide contraception to youth. *(Nurture was renamed Summit for live prototyping, and promising features from the Interactive Narratives prototype were integrated.)*

Digital Self-Assessment (or Youth Virtual Clinic): This digital or short message service (SMS) learning platform helps providers put unbiased counseling into practice by roleplaying with virtual youth characters. Providers are given real-time feedback on their counseling and can self-assess where improvement is needed through interactive quiz-style activities.

⏵ **Provider Forum / Connect:** This digital mobile forum educates providers and connects them with an online community of peers. Content is focused on addressing the fears and biases of providers, normalizing contraception for youth clients, and addressing myths about methods. The underlying assumption is that a mixed forum with social peer interaction and easily accessible technical information will help shift group norms towards less biased services. *(Provider Forum was renamed Connect for live prototyping, and promising features from the Youth Virtual Clinic prototype were integrated.)*

Bypass the Biases: This contraceptive counseling job aid aims to help providers support their youth clients to make informed choices based on client preferences and evidence rather than the provider's biases.

Youth Bill of Rights: Visual and audio materials in the clinic inform providers and youth about client rights and expected quality standards in every consultation. The underlying assumption is that it will create more accountability by reminding providers of expected standards and supporting young people to know what they have a right to expect from a provider.

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[1] Youth-facing solutions were introduced later on in the design process (during a Technical Review Board convening after rough prototyping of provider-facing solutions). The intention was to broaden the scope and hopefully intensify the effects of the intervention.

Concepts Selected for Rough and Live Prototyping...

🟢 **Seen Doing Well / Rewards:** This system rewards providers based on the quality of services and interactions with youth clients, as measured by client exit data. The assumption is that the quality of services provided to youth will improve if providers are incentivized and recognized for good service. *(Seen Doing Well was renamed Rewards for live prototyping.)*

Youth-Facing Concepts

Treasure Box: This interactive physical learning tool in the clinic waiting area has text, visual, and audio content to help youth learn about the types of methods and basic SRH information before entering the consultation room. The underlying assumption is that if clients' baseline knowledge of contraceptive methods increases, they will be more likely to ask about different methods when talking to the provider.

🟢 **Super Girl:** With this interactive mobile audio platform, a young client is primed or coached by a Super Girl character on what to expect during the consultation and how to navigate potentially challenging situations with a biased provider during the consultation, including specific phrases to use if a provider refuses service. The underlying assumption is that if clients are prepared to respond to provider pushback, they will be more confident and able to advocate for themselves in the real consultation. *(Super Girl incorporated elements from Treasure Box for live prototyping.)*

Question Tree: This tool on the wall in the clinic waiting area shows youth SRH-related questions that are frequently asked by their peers and allows them to add their own questions. The assumption is that seeing other young people's questions will increase their confidence to ask questions during the consultation with a provider.
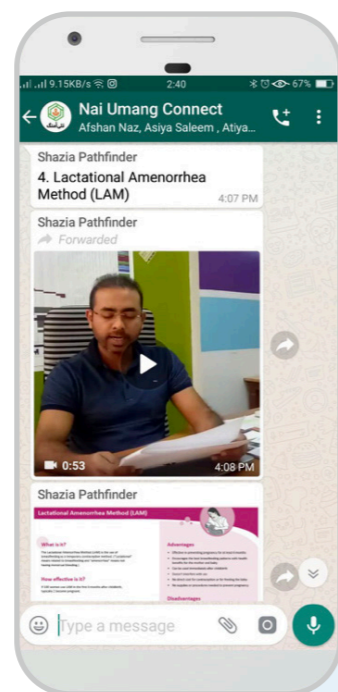
Photo: YLabs, with written consent from participants

Testing of Data-Collection Modalities

A key challenge embedded within Beyond Bias was how to collect accurate and adequate data from youth clients about the details of their interaction with a provider after their consultation experience.

The success of the Rewards pillar in the final intervention design (see page 9) depends on clients providing data that can then be used to recognize high-performing facilities and offer improvement recommendations to low-performing ones. Existing quality assurance data on provider counseling behavior were not sufficient for the purposes of Beyond Bias, because frequency of collection varied across the three countries, and the data categories were not specifically focused on assessing the existence of bias toward young, unmarried, and/or nulliparous clients.

During the prototyping phases of the HCD process, Beyond Bias explored the feasibility and user-friendliness of several new digital data collection modalities. These were 1) a self-administered audio survey via a tablet installed in the clinic, and 2) an SMS or interactive voice response (IVR) survey sent to clients after receiving counseling or services at the clinic. To test these approaches, Beyond Bias designed and developed a custom tablet application with audio-visual guidance to ensure its accessibility to non-literate clients. Tablets were secured in kiosks in 29 facilities in Tanzania, Pakistan, and Burkina Faso; 3,215 clients completed surveys over the three-month live prototyping period. Due to project timeline constraints, simultaneous live prototyping of a full SMS/IVR system was not feasible, so the SMS and IVR mobile survey idea was rough prototyped with approximately 25 young women in each country.

Key learnings that may be relevant to implementers grappling with similar questions regarding data collection from youth clients include the following:

1 **Conventional questions frequently used in client feedback surveys** such as, "Would you recommend this provider to a friend?" generally did not yield useful client responses due to clients' strong deference to providers as authority figures. Clients nearly always replied affirmatively to such questions, even if they clearly were treated poorly or received biased counseling. Questions that proved more useful were specific, objective, and without an obvious socially desirable answer (e.g., "Did the provider discuss condoms with you?").

2 **Social stigma around young, unmarried women using contraception** means that clients are reluctant to give a phone number or share any feedback on their clinic experience that could be traced back to them. Follow-up surveys via IVR or SMS were seen by many young women as threats to "outing" them to partners or family members.

3 **Low literacy and low phone ownership rates** among young women hinder success of mobile-based methods, particularly in Pakistan and Burkina Faso. If young women did have access to a mobile phone, it was often shared with a sister, parent, or cousin, so it was not a private communication channel to receive a call or SMS about contraceptive services.

4 **Gaming of unsupervised devices by providers must be carefully accounted for, particularly when using client survey data** to publicly recognize clinics for their performance compared to other clinics. While live prototyping the tablet survey kiosk, the Beyond Bias team noticed irregularities in survey data and developed criteria to identify survey entries that were likely fraudulent (i.e., entered by providers). The criteria for flagging an entry were a) surveys completed in under one minute, b) surveys submitted well outside of clinic hours, and c) a string of two or more surveys completed within one minute of each other. Using these criteria, we removed 32% of entries in Tanzania, 15% of entries in Pakistan, and 7% of entries in Burkina Faso.

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Testing of Data-Collection Modalities

The suitability assessment of the various data-collection modalities to meet the objectives of Beyond Bias is summarized in the table below. Ultimately, Beyond Bias chose to use human enumerators instead of a digital method to collect client feedback data, because quality, reliable data was needed not only for the Rewards concept but for the RCT evaluation of the intervention.

|	KEY TAKEWAYS
Human enumerators stationed at each clinic	• Good quality, relatively reliable data • Expensive
Audio-visual survey app on an unsupervised t ablet	• Decent response rate (30-50%); decent data quality • Gaming by providers must be accounted for • Barriers to scale: IT maintenance, electricity, costs of unit
IVR follow-up survey on client's mobile phone	• Scalable and moderate cost • Low response rate for FP-related follow-up • Many clients are unwilling to share phone number to receive call, if phone is shared with family members
SMS survey to client's mobile device	• Scalable and moderate cost, but not accessible to non-literate clients (Non-literacy rates are highest among young women in all three contexts.) • Literate clients unwilling to engage due to privacy concerns on shared devices (especially in Pakistan and Burkina Faso)
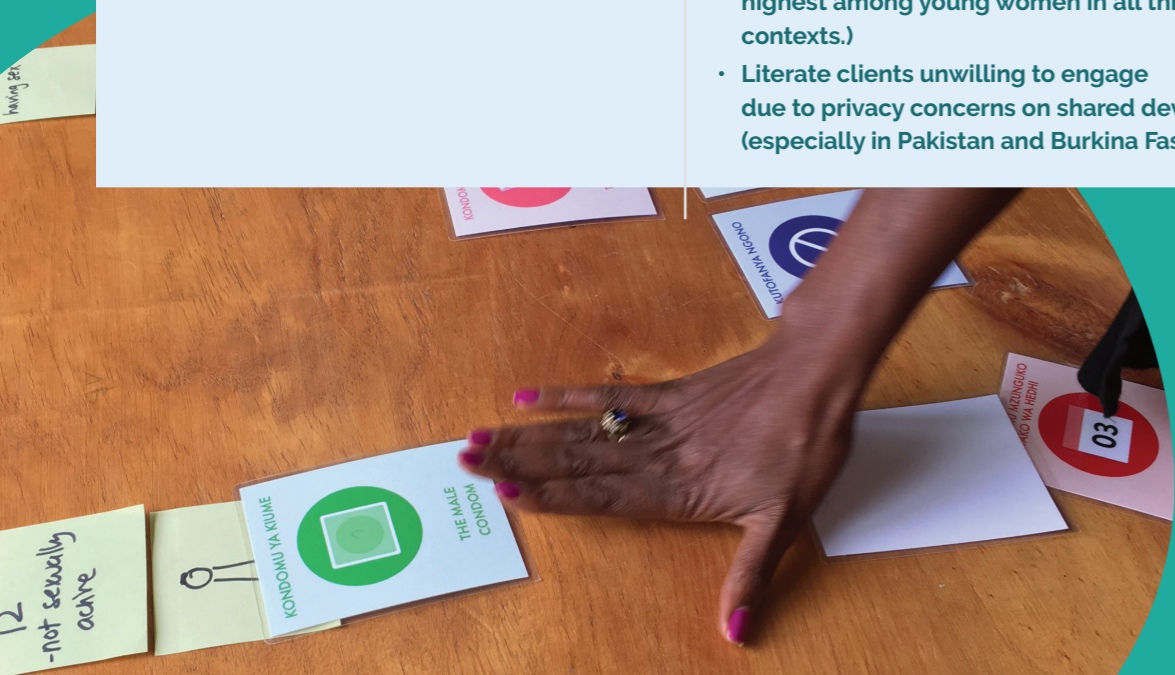
Photo: YLabs, with written consent from participants

## An Integrated Intervention, Adapted by Each Country

The finalized solution design that advanced into implementation was a refined combination of Summit, Connect, and Reward solutions. The three-pillared intervention is designed to support health care providers at every phase of their journey from developing awareness of their own bias to becoming advocates for improving contraceptive services for youth in their community.

The finalized solution design that advanced into implementation was a refined combination of Summit, Connect, and Reward solutions. The intervention uses the Stages of Change behavioral model[2] as an underlying theoretical framework. Despite promising qualitative feedback and preliminary quantitative data (particularly from Tanzania and Burkina Faso), the youth-facing live prototype Super Girl did not advance into implementation. The degree to which priming youth changes a young person's consultation outcomes was difficult to assess quantitatively and risked complicating the project's RCT evaluation of the provider-facing interventions. Priming youth clients through scenario coaching directly before a consultation seems to be a promising tool to improve service quality and is recommended for further exploration in other projects.

Although the overall intervention strategy is the same across the three countries to increase scalability, Beyond Bias used the provider segmentation analysis* to tailor the program for each country to increase the likelihood of behavior-change impact. For example, the Connect pillar of the intervention (described on the following page) uses discussion-driven case studies to help providers identify how to apply unbiased practices in their own work. In Pakistan, the case studies are mostly focused on recently married youth clients and highlight the safety of long-acting reversible contraceptive methods to address infertility myths among the dominant provider segment there. For Tanzanian providers, in contrast, the case studies often focus on unmarried clients and seek to highlight the safety of hormonal methods, a concern for the dominant segment there. Program-delivery methods also varied slightly by country to accommodate provider context and need. In Pakistan the case study discussion was delivered and facilitated entirely via a WhatsApp group since all providers had smartphones and preferred a digital forum. In Tanzania, not all providers had smartphones, and data costs are higher. While WhatsApp was used as a celebration space to highlight small wins and success stories across facilities, the in-depth case study discussions happened in person at the facility level.

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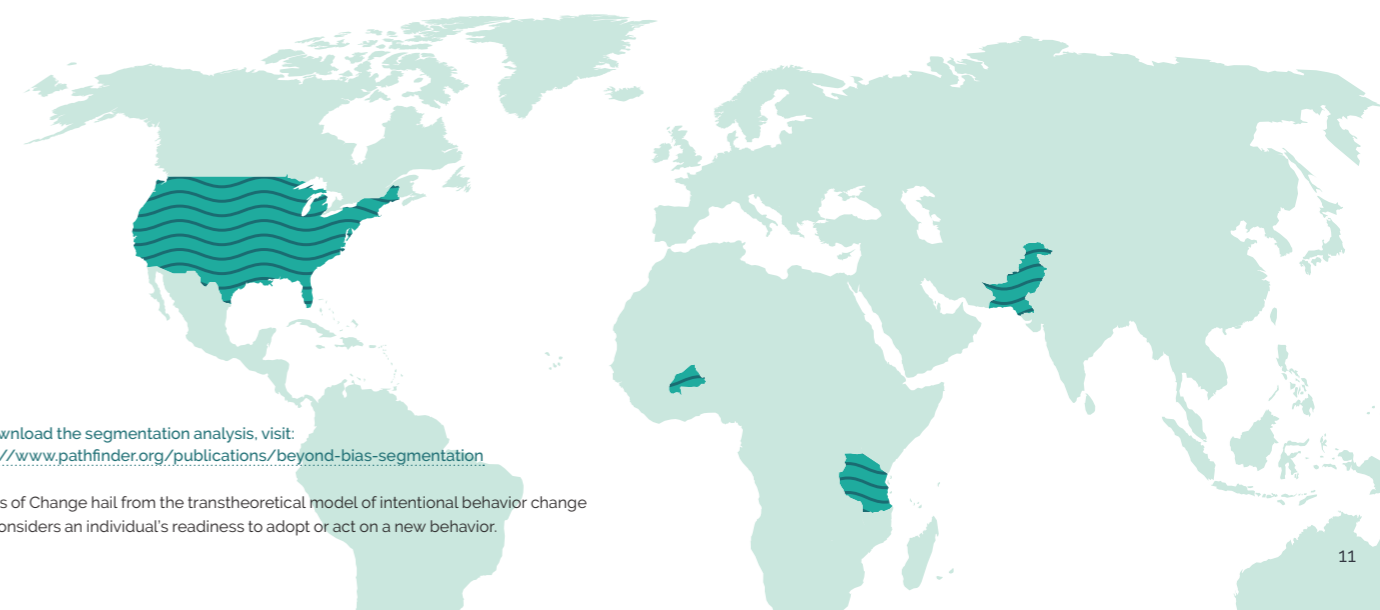
* To download the segmentation analysis, visit:
https://www.pathfinder.org/publications/beyond-bias-segmentation

[2] Stages of Change hail from the transtheoretical model of intentional behavior change that considers an individual's readiness to adopt or act on a new behavior.

The Three Pillars

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 75 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). The event went through multiple rapid iterations based on user feedback during the prototyping process and built upon the lessons of existing approaches such as values clarification and attitude transformation (VCAT). This allowed the project to improve Summit's ability to effectively support providers to reflect on their own biases, publicly discuss them, and create an action plan for shifting their biases alongside their peers. Summit's core elements include the following:

Personal, emotional stories shared by youth and other providers

Professional permission from respected authority figures to serve youth

Guided reflection activities to support providers to own their biases

Individual action planning and public commitment to translate motivation into action

Connect

Connect is an ongoing peer-support and learning forum in which providers problem solve together to apply unbiased practices in their daily work.

Connect is conducted through a digital discussion group (WhatsApp) and/or an in-person forum led by facility in-charges who participated in a three-hour training. The Connect curriculum is tailored proportionally to the provider segments in each country (see page 11). The prototyping process enabled the Beyond Bias team to adapt the content to be valuable, relevant, and motivational to providers, so that they do not feel like they are in school or are being nagged about something they do not prioritize. In Pakistan, for example, where the providers are private-sector solo operators, the Connect curriculum included tips on business management, marketing, and customer retention techniques. This significantly increased providers' sustained engagement with the forum and peer community. Connect's core elements include the following:

Trusted technical experts and practical tips to dispel medical misinformation and ensure credibility of the content

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

Safe space to share struggles and successes with peers, creating a sense of group identity and belonging

Regular review of unbiased service-delivery goals to support providers in maintaining motivation and group commitment

The Three Pillars

Rewards

Rewards is a growth-oriented non-monetary performance-based incentive assessed through client feedback on provider behavior.

Facilities receive report cards with performance data and recommendations for improvement, and those with high improvement scores get public recognition for their progress. Through prototyping, the Beyond Bias team learned what types of nonfinancial 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 made the most improvement over time (i.e., don't just recognize the "most-valuable player" but also the "most-improved player"). Rewards' core elements include the following:

A standardized rubric of excellence that enables measurable progress and clear performance targets

Client feedback, captured directly after counseling, with objective questions about provider behavior

Institutional recognition of providers in front of their peers for improvement and maintenance of quality

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Bringing the three pillars together creates a robust behavior-change strategy (Figure 3) that we believe has potential to shift provider bias.

Through *Summit* providers activate their motivation and self-awareness of bias. Through *Connect* they apply knowledge and motivation, supported by a community of peers and trusted experts. And through *Rewards* they achieve recognition for performance.

For more information about the Beyond Bias project approach and the integrated intervention, including visuals, see the presentation Tackling Provider Bias in Contraceptive Service Delivery: Lessons from the Beyond Bias Project.*

Figure 3. Beyond Bias Behavior-Change Strategy

Photo: YLabs, with written consent from participants

Behavior-Change Strategy

PHASE	ACTIVATE Pre-Contemplation Contemplation Determination	APPLY Action, Relapse	ACHIEVE Relapse	OUTCOMES (A Principles Framework)
EXPERIENCE	SUMMIT	CONNECT	REWARDS	Sensitive Communication Safe, Welcoming Space Seek Understanding and Agreement Security of Information Say Yes to a Safe Method Simple, Comprehensive Counseling
BEHAVIOR-CHANGE MECHANISMS	Humanize bias and hold up a mirror for providers / Improve emotional connectivity with youth / Address provider's fear of community backlash	Address concerns of fertility delays / Educate around safety of methods for youth / Activiate contextualized agency	Create accountability for service quality / Offer visible performance-based awards / Shift professional norms	

Key Tips for Addressing Bias

1 **Name Bias But Don't Shame Bias**

Create environments and conditions where providers feel supported and safe in admitting their own biases, without blame or fear of punishment.

2 **Acknowledge Constraints; Activate Agency**

Help providers focus on actions they can take to address bias which are feasible in their facilities, such as how they listen and speak to a young person, and what information about methods they provide.

3 **Reward Growth Over Good**

Reward providers' progress towards standards of unbiased care—The Six Principles— rather than their ranked, absolute performance, alone.

4 **Connect Bias to What Providers Care About**

Demonstrate value for providers via recognition from their teams (public sector) and advice on business sustainability and customer retention (private sector).

5 **Celebrate Providers' Knowledge, Experience, and Commitment**

Recognize providers as the experts and collaborators who can support their peer providers to improve service and build a bright future for youth

Photo: Dominic Chavez, CC

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