1-31-2023

Provider Behavior Change: Social and Behavior Change Approaches to Quality of Care in Family Planning—Slide deck

Breakthrough RESEARCH

Breakthrough RESEARCH Legacy and Learning Event Series

JANUARY 31, 2023

Provider Behavior Change:

Social and Behavior Change Approaches to Quality of Care in Family Planning

Recordings (English and French) of this webinar are available at:
https://knowledgecommons.popcouncil.org/series_breakthrough-res_pbc/

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Breakthrough RESEARCH FOR SOCIAL & BEHAVIOR CHANGE

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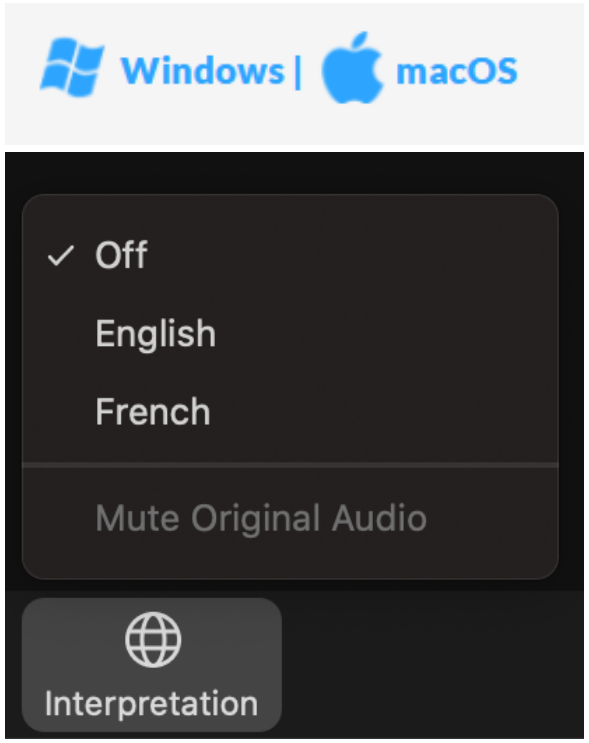

Click on the Interpretation icon on the bottom right of your screen and select your preferred language.

Cliquez sur l'icône Interprétation en bas à droite de votre écran et sélectionnez votre langue préférée.

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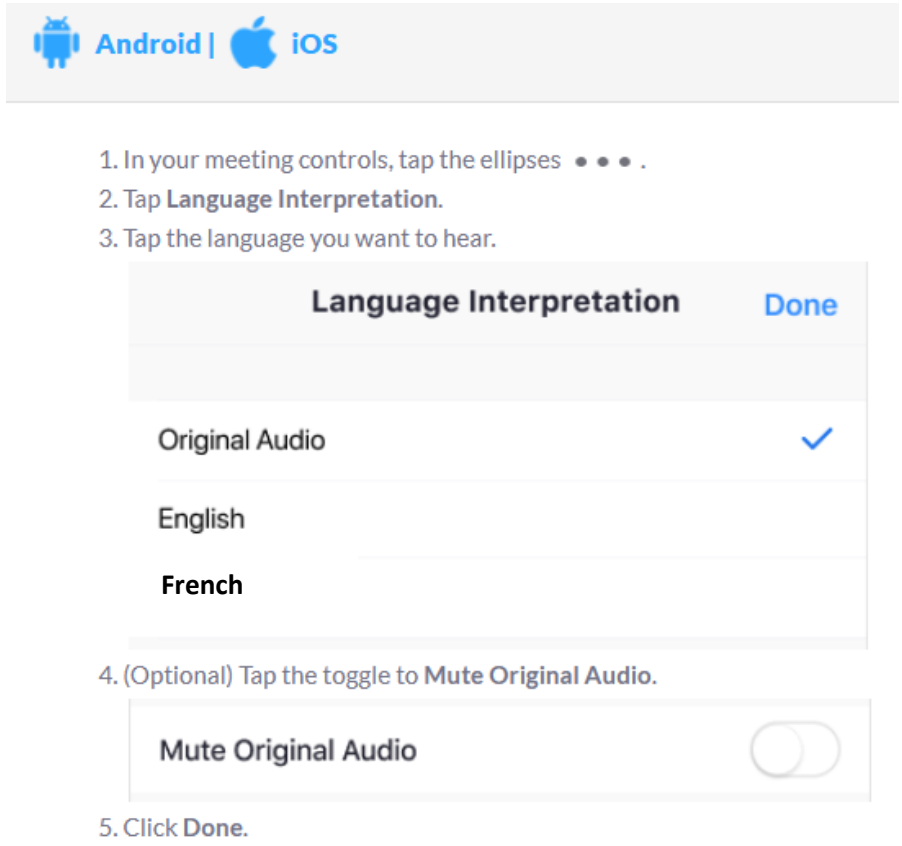

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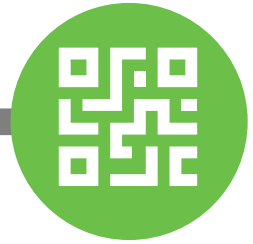
Under “meeting controls” press the three (3) dots then press **Language Interpretation**. Select English or French.

*Sous « contrôles de la réunion », appuyez sur les trois (3) points, puis appuyez sur **Interprétation de la langue**. Sélectionnez l'anglais ou le français.*

Logistics for today

Use the chat! Ask questions (in English or French) at any time to the group or directly to a moderator if you need technical assistance.

We'll be using Mentimeter today—you can use this on your phone, tablet, or laptop.



QR codes and links (via chat) will be provided throughout the webinar for you to access resources and tools.

Links to webinar recording, presentation, and resources will be shared.

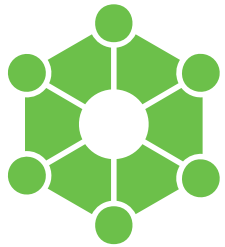
Welcome!

Breakthrough RESEARCH

- Flagship SBC research and evaluation project for USAID Global Health Bureau to drive the generation, packaging, and use of innovative SBC research to inform programming.
- Six-year project—August 2017 to July 2023
- Led by the Population Council in collaboration with our consortium partners: Tulane University, Avenir Health, Population Reference Bureau, Institute for Reproductive Health at Georgetown University, and ideas42.

Breakthrough RESEARCH Snapshot

Worked in **19** countries



Engaged with **21** local and global partners

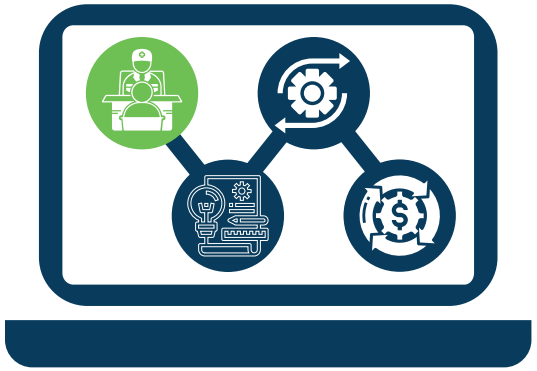
Conducted **53** research studies

Published **27** articles in peer-reviewed journals to date

Cited **94** times in grey and peer-reviewed literature to date

Webinar objectives

- 1st of 4 complementary legacy and learning webinars
  1. Provider Behavior Change: SBC Approaches to Quality of Care in Family Planning
  2. Advancing SBC Measurement for Family Planning
  3. SBC and the Enabling Environment for Family Planning
  4. Costing for Family Planning SBC



- Highlight evidence, insights, and learnings from the past 6 years from Breakthrough RESEARCH's work to advance provider behavior change (PBC) programming and fill critical PBC evidence gaps
- Share resources and evidence-based, practical tools you can use to strengthen PBC programs, measurement, and research

Roadmap for today

1. PBC in Family Planning
2. Breakthrough RESEARCH's State-of-the-art Evidence
3. Breakthrough RESEARCH's PBC Tools You Can Use
4. Call to Action
5. Discussion and Q&A

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Key Message

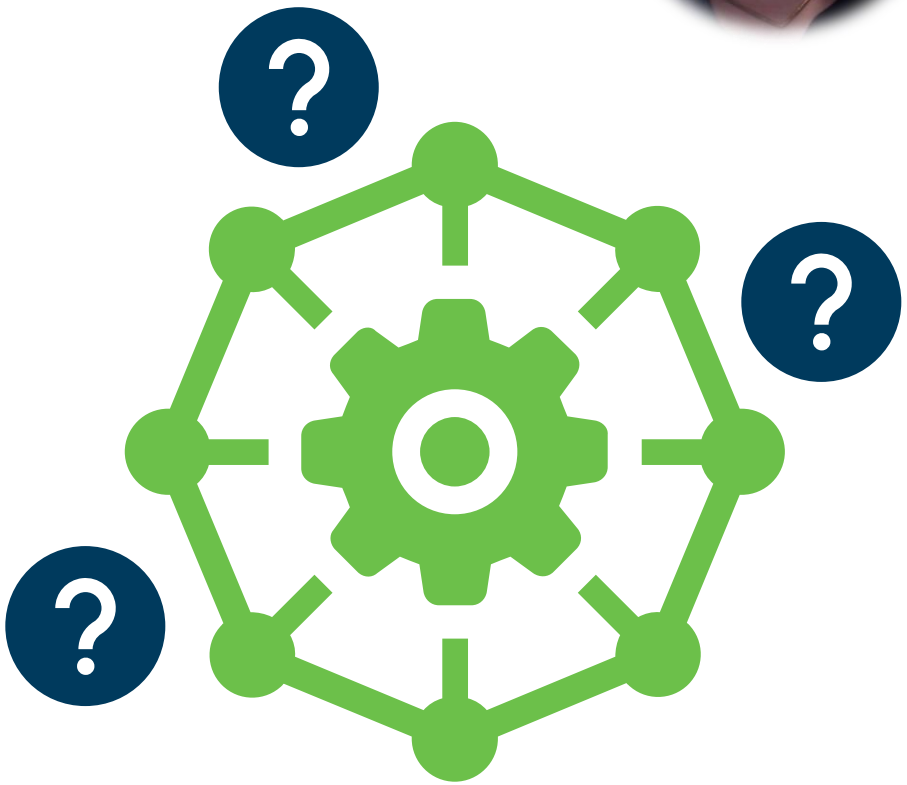
An SBC approach within PBC to improving quality of care in family planning, addresses behavioral antecedents of provider behavior and has the potential to result in multiple impacts at individual, community, and system levels.

PBC is complex

- Limited evidence on approaches to measure and address provider attitudes and provider bias.
- Need to better understand the pathways from intervention to outcome.
- It can be difficult to determine how the PBC intervention influenced the intended outcomes—particularly for more distal outcomes, including client outcomes such as informed and voluntary method choice and uptake, method continuation, and experiences of care.

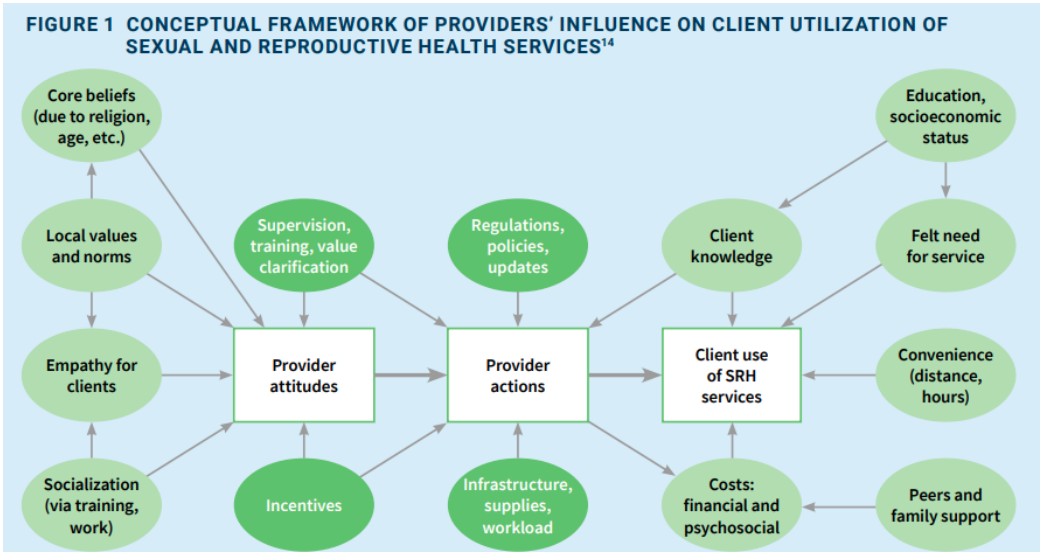
PBC and quality of care

- Traditionally viewed through health systems strengthening or client-focused quality of care frameworks.
- These frameworks often do not reflect behavioral determinants of the provider such as attitudes, self-efficacy, and perceived norms.



PBC in family planning

- Effective client-provider interactions are essential to consistent demand and uptake of family planning services, but are often influenced by provider behavior.



- Behavioral economic interventions hold promise to improve family planning outcomes through provider-facing interventions.

Key Message

Health systems are comprised of interconnected stakeholders whose effectiveness is influenced by power dynamics and a range of drivers of provider behavior.

State-of-the-art Evidence

ADVANCING **PROVIDER BEHAVIOR CHANGE** PROGRAMMING

THIS RESEARCH AND LEARNING AGENDA HIGHLIGHTS:

- The importance of addressing provider behavior to improve behavioral and health outcomes.
- Gaps in the existing evidence base for provider behavior change programming.
- The priority research and learning questions and the consensus-driven process used to derive them.
- The roles of key stakeholders for putting the learning agenda into action.

Service providers play a fundamental role in health promotion and disease prevention, care, and overall well-being of their clients and communities. Effective client-provider interaction is pivotal for consistent demand and uptake of health services. Evidence shows that poor client-provider interactions can have a negative influence on use of health care. For example, unsatisfactory interactions with health care providers, such as lack of respectful care, can discourage future choices to deliver a child at a facility, seek prompt care, or ask important questions.[1] The quality of client-provider interaction can be influenced by the type or setting of provider (community-based, facility-based, private), their knowledge, attitudes, and biases, as well as social norms and structural factors like privacy and confidentiality.

Various approaches such as training, supportive supervision, and financial incentives have been used to address these factors with mixed results. For example, a randomized evaluation in Nigeria found that use of a supervisory checklist for facility-based providers resulted in improvements in provider knowledge of malaria and appropriate prescription practices.[2] However, supportive supervision was not significantly associated with correct prescription by providers in other studies in Tanzania[3] and Malawi.[4] Providers' personal biases can also discourage the use of particular medical interventions especially among certain populations (for instance, intrauterine devices for nulliparous women). A

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Research and Learning Agenda (RLA) for Advancing PBC Programming

RLA for Advancing PBC Programming

Breakthrough RESEARCH developed two consensus-driven research and learning agendas—one for integrated SBC programming and another for PBC programming.

The RLA for Advancing PBC programming lays out a set of questions that articulate what is needed to better understand factors that influence providers' behaviors—behaviors that, in turn, can influence clients' family planning outcomes.

Organizational Characteristics and Values

- What norms (such as facility, profession/seniority, community) are most influential in shaping provider behavior in interpersonal communication with clients?
  - How do these factors vary by client and provider profile?
  - How do they vary across health areas and in different geographical contexts?
  - How do facility-based clinical practices/standards shape provider behavior?
  - Which norms have the largest impact on how providers deliver quality counseling?

Effectiveness

- Does improving the behaviors/practices of health providers influence the quality of care provided?
  - What are the most effective SBC approaches to enable/motivate/facilitate (different cadres of) providers to provide respectful, client-centered care (such as staff recognition through incentives to provide postpartum family planning counseling)?
  - What are the most effective non-communication-based SBC interventions to improve provider behaviors (for instance, a suitable waiting room)?
- How does addressing the factors that influence provider behavior (normative, structural, behavioral) lead to improved health outcomes?

Intervention Strategies

- How does SBC programming affect the organizational culture of health facilities and systems to create an enabling environment for positive provider behaviors (for instance, improved attitudes, performance, shifts in norms)?
  - What intervention designs are effective in addressing organizational/facility-level norms pertaining to provider behavior?
- Which intervention(s) or combinations of interventions are most important to improving the quality of provider counseling?
  - How does the quality of provider counseling influence utilization of services among clients?
  - How does the quality of provider counseling influence adoption of positive behaviors among clients?
  - Which interventions improve perceptions of service quality and provider accountability?

Measurement

- How can we best assess/measure the quality of client-provider interactions from client and provider perspectives?
- How can we best measure provider attitudes, norms, and biases that influence their performance and adherence to timely and respectful client-centered care practices?

RLA for Advancing PBC Programming: Putting the Agenda into Practice

DONORS

- Use the agenda to fund stand-alone or programmatically embedded research.
- Coordinate and align investments across donors.

SBC & SERVICE DELIVERY ORGANIZATIONS

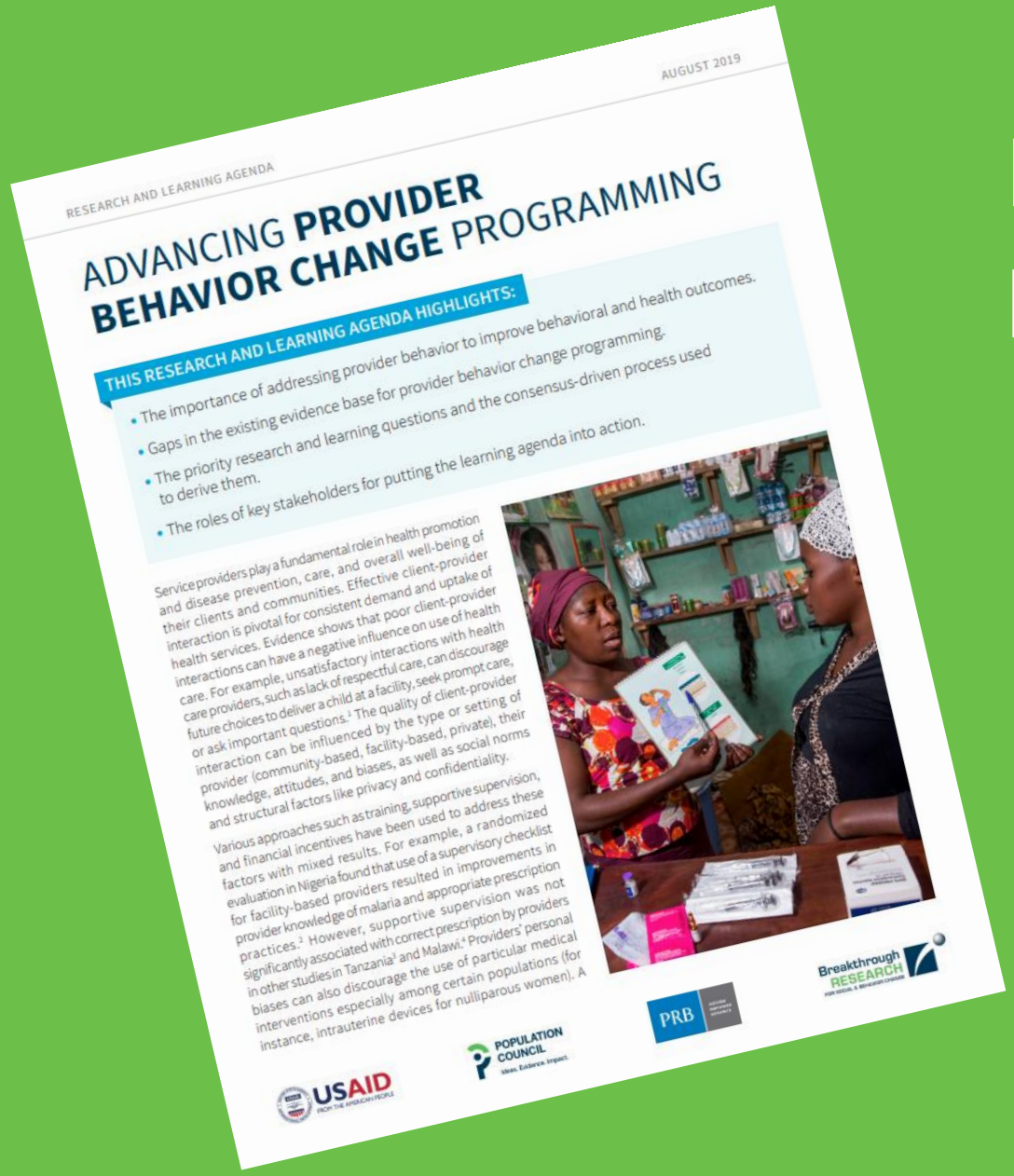
- Update routine monitoring and evaluation systems to capture key information within existing programs and activities to help answer priority questions from the agenda.
- Use emerging research/program evidence to course-correct program approaches.

GOVERNMENTS & POLICYMAKERS

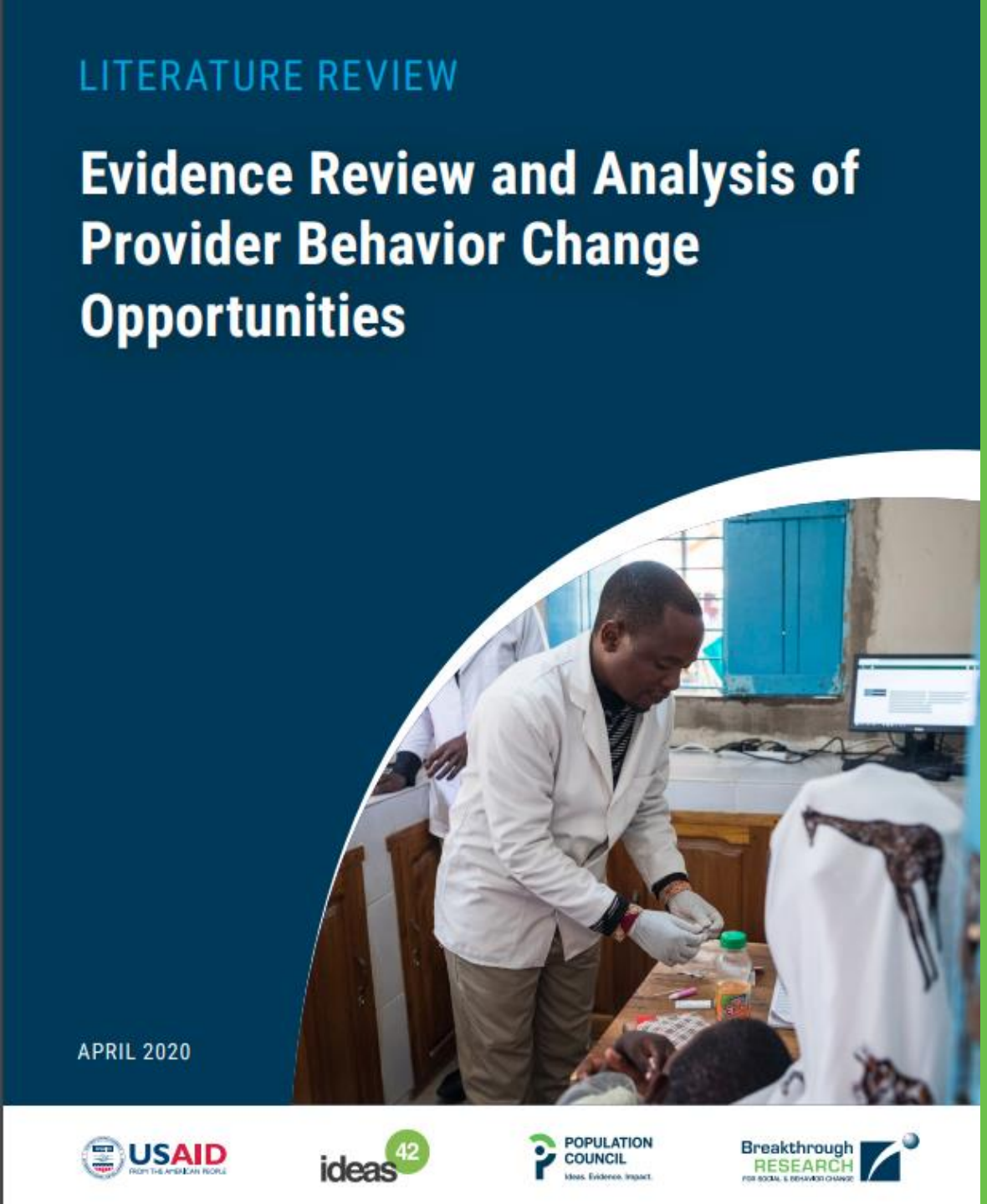
- Promote implementation science research agendas to answer key questions about PBC programs.
- Use emerging research/program evidence to influence strategies and update relevant policies.

RESEARCH INSTITUTIONS & UNIVERSITIES

- Develop and share innovative research designs and measurement tools and generate evidence on the priority questions from the agenda.
- Team up with program implementers to help answers questions within existing programs.

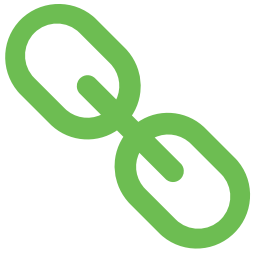


RLA for Advancing PBC Programming



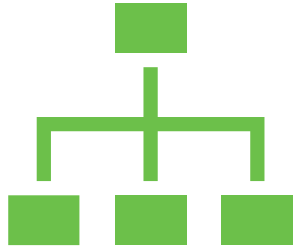
Evidence Review and Analysis of PBC Opportunities

Evidence review and analysis of PBC opportunities



1. What is the potential link between this provider behavior and health outcomes?

2. What interventions have attempted to improve this provider behavior, and what is the evidence of their effectiveness?



3. To what extent are the challenges driven by behavioral, rather than structural (i.e., infrastructure or clinical skills) factors?

Evidence review and analysis of PBC opportunities

2 family planning provider behaviors with the greatest behavioral economics potential:

1. Provider counsels women on a full suite of methods.

2. Provider counsels women in unions on spacing.

Insights from PBC research and practice

5 insights and evidence-informed design tactics to support provider behavior

1 CLINICAL CUES

Integrate cues to important but neglected aspects of care into the signs, forms, and markers that providers are exposed to in their day to day

2 FEEDBACK LOOPS

Build tools and channels through which providers can learn from their daily experience and incite them to consider effects of their actions that they might not have expected

3 PRACTICAL MISMATCHES

Match guidance to the practical environment and make correct provider behavior the easiest one—both practically and psychologically

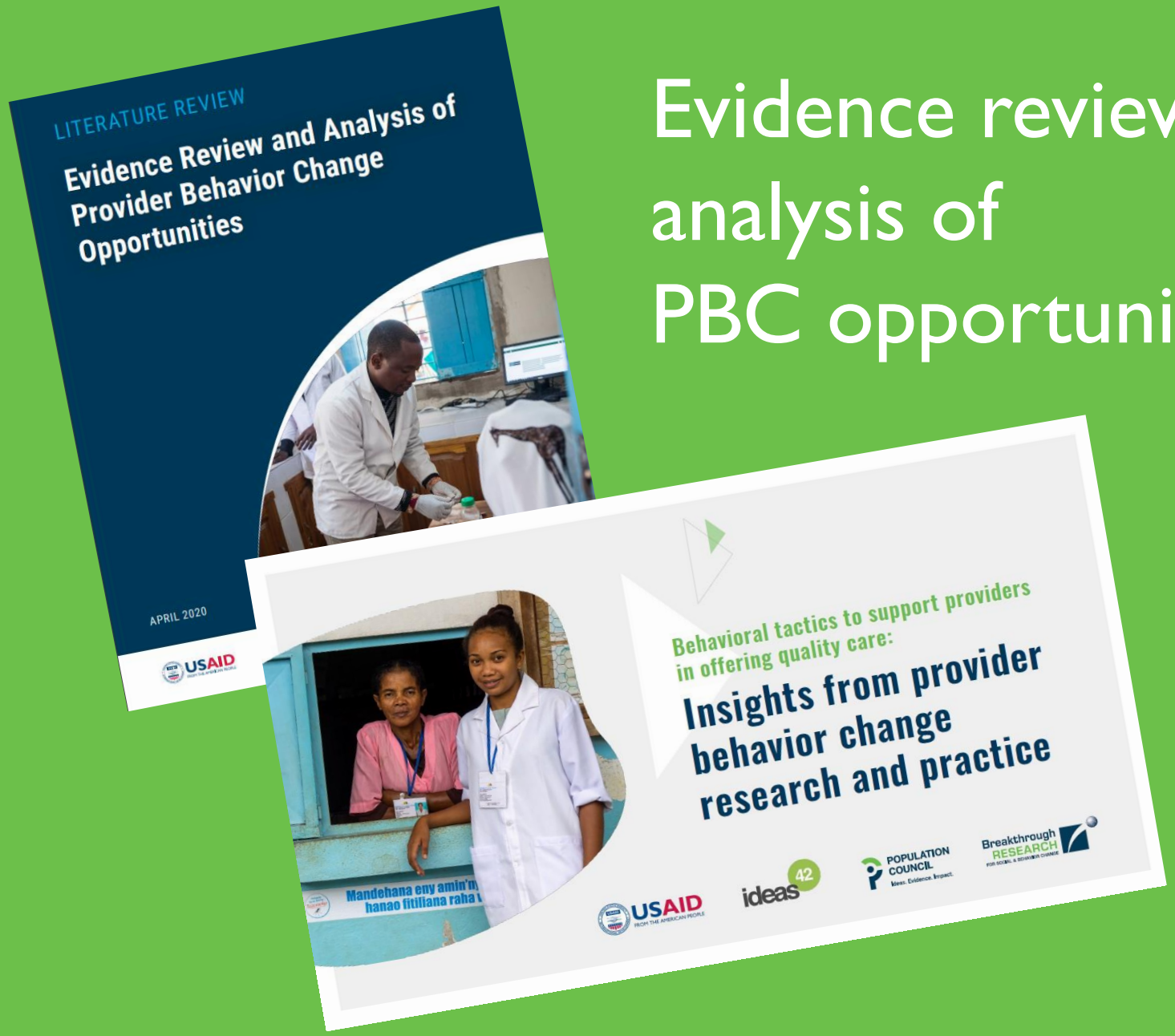
4 MULTIFACETED IDENTITIES

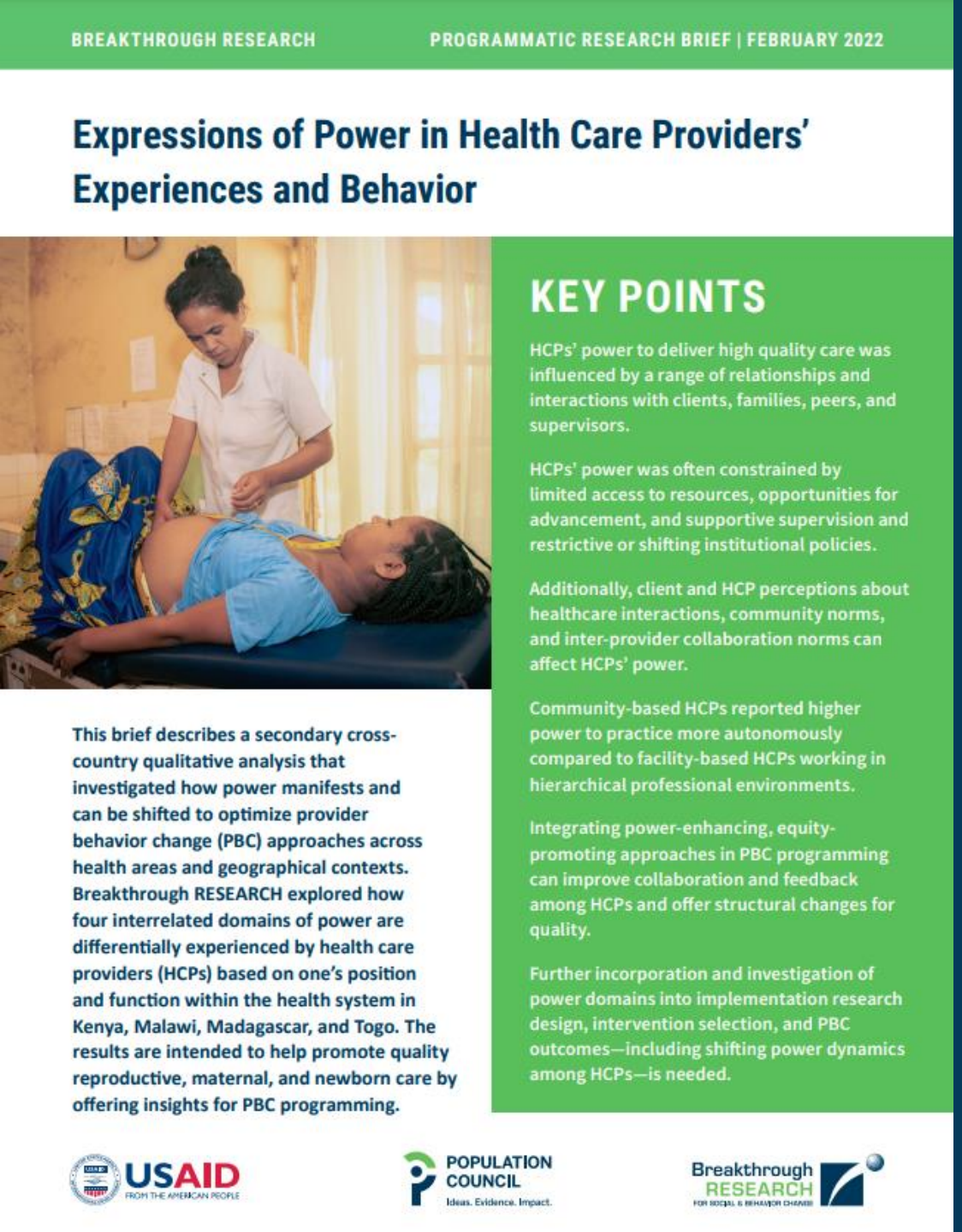
Enable providers to reconcile their personal identities and past experiences with their professional oblations

5 SCARCITY

Alleviate the burden by reduction hassles and inefficiencies thoughtfully, shifting responsibilities, and recentering attention toward what is within the provider's control

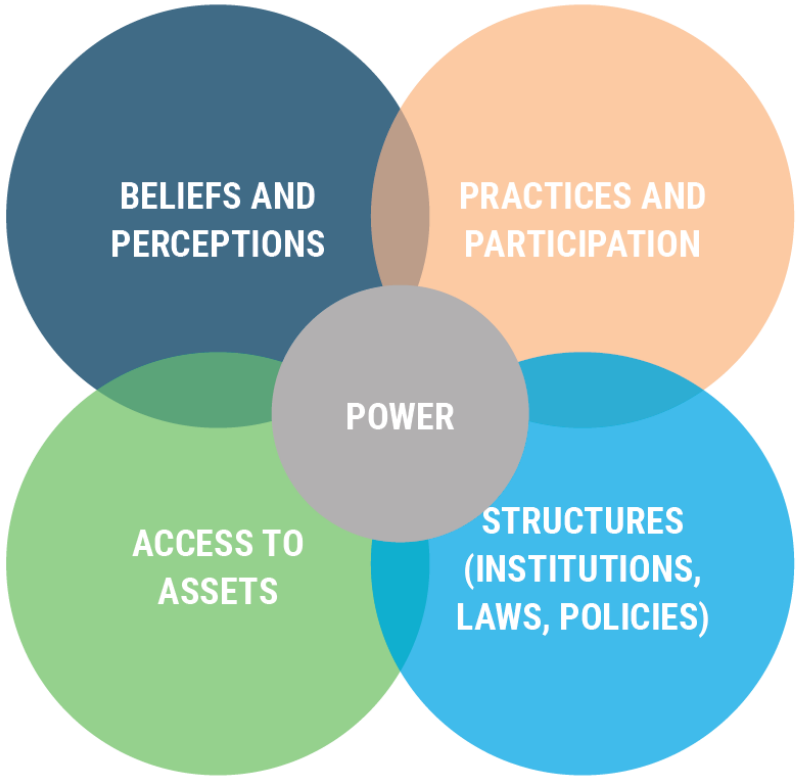
Evidence review and analysis of PBC opportunities





Expressions of Power in Providers' Experiences and Behavior

Expressions of power in providers' experiences and behavior



Adaptation of Betron et al. 2018. Mapping of power and gender domains to HCP experiences.

For providers, several types of power may be at play:

- Power within—internal capability or sense of self-worth, self-knowledge
- Power to—agency to act in a certain way despite constraints and opposition (e.g., serve a client)
- Power with—collaborating with other providers to provide health services
- Power over—leveraging resources and challenging authority (e.g., medical expertise or age)

Expressions of power in providers' experiences and behavior

Beliefs and Perceptions

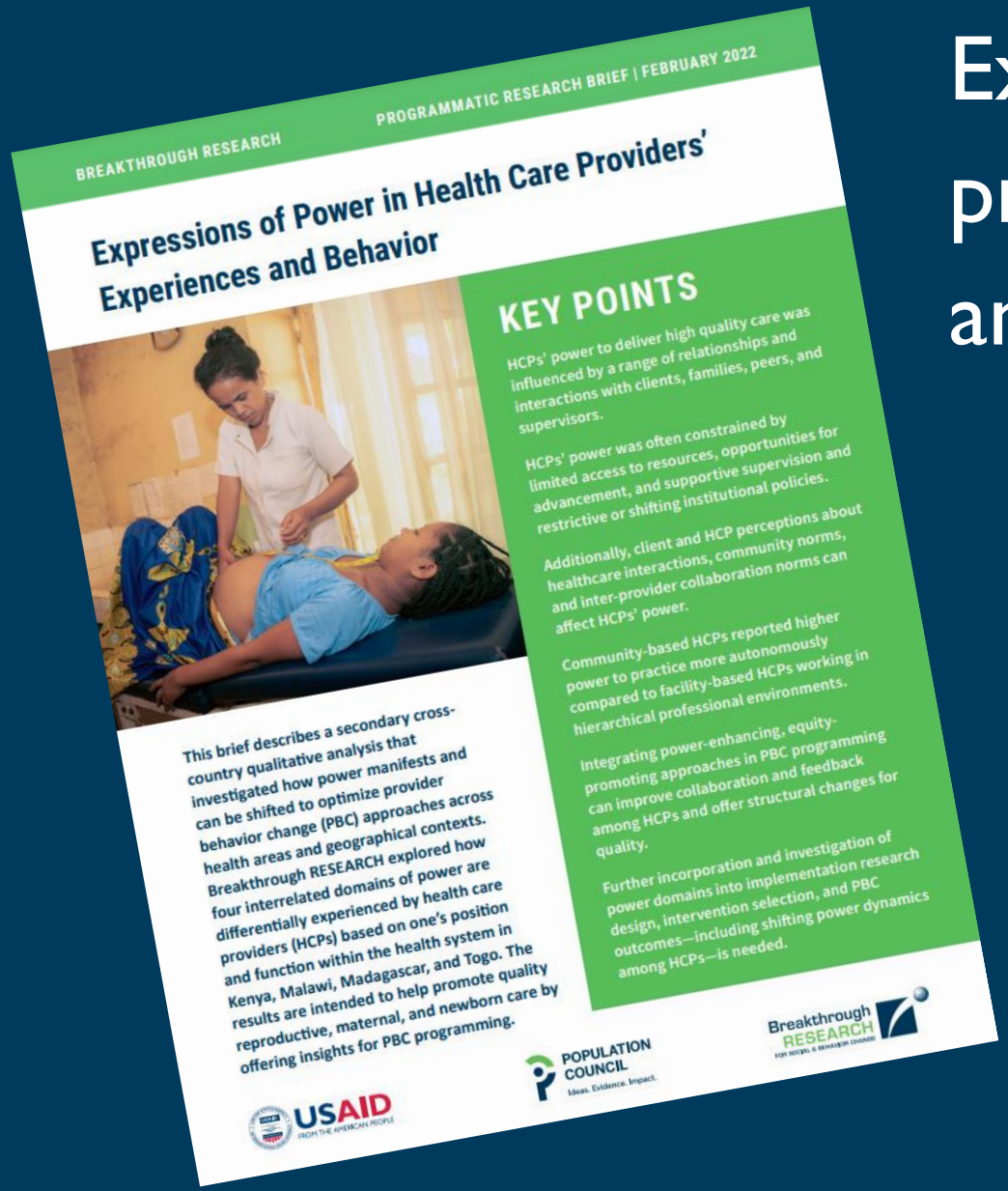
"In terms of difficulties, some people consider that we're not old enough to speak to them [couples], so it's sometimes difficult."

—Female, Community-based Provider, FP/RH, Togo

Access to Assets

"What I don't like as much is the fact that the work of a CHW is really heavy. We are the ones doing all the upfront work before people come to see a [facility-based] provider but we are not treated as we should be. That is discouraging."

—Female, Community-based Provider, FP/RH, Togo



Expressions of power in providers' experiences and behavior

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Key Message

Defining and measuring provider behavior and its determinants is complex and dynamic, requires continuous nurturing, and is imperative to sustain change for providers that contributes to improved health outcomes for clients.

Tools You Can Use

PBC tools you can use

- PBC measurement learning module
- Provider attitudes scale
- Research spotlights

PBC Measurement

Overview of training modules

The training is divided into two modules :

Module 1: Understanding provider behavior and PBC

Module 2: Examples of PBC measures and how we can inform your work using Breakthrough RESEARCH examples and others

Understanding provider behavior and PBC

What is provider behavior?

A range of actions that include but are not limited to facility management, adherence to clinical protocols, supervision, and client-provider interaction that is the outcome of a complex set of factors that are both internal (e.g., attitudes, values, and beliefs) and external (e.g., supervisor support, access to professional development, and supportive workplace environment) to the provider.

Source: Sherard D, May S, Monteforte E, Hancock H. Provider Behavior Change Implementation Kit. Johns Hopkins University; 2013.

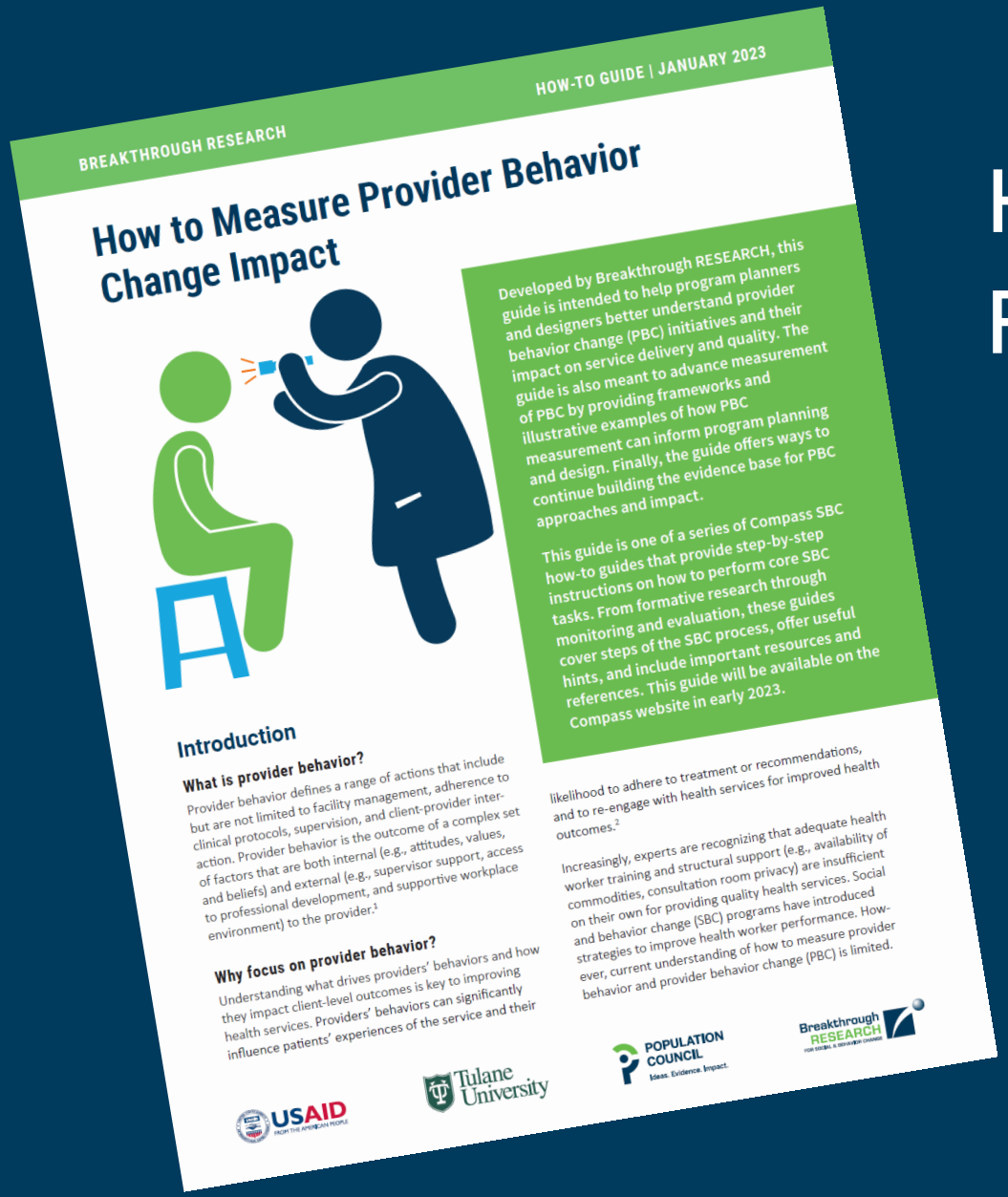
Examples of PBC measures

Using the PRECEDE-PROCEED Model to guide PBC measurement

- **Predisposing factors**—an individual's attitudes, beliefs, and perceptions
- **Reinforcing factors**—those that follow a behavior and determine whether, for example, a health worker receives positive (or negative) feedback by their supervisors
- **Enabling factors**—resources and skills required to make desired behavioral and environmental changes (e.g., availability of medical supplies)
- **Ability**—competency and skills of the provider
- **Provider behavior/Client-provider interactions**—client reception, person centered care and clinical management

What are some strategies to measure PBC?

Strategies	Pros	Cons
Mystery clients	• Reduces observation bias • Captures provider behavior	• Require high level of training and strict protocols • Higher cost • Can be disruptive of services
Client-provider observations	• Avoids self-report • Eliminates recall bias • Captures provider behavior	• Prone to observation bias • Requires high volume of clients to be cost-effective
Client exit interviews	• Can be combined with observations for data triangulation • Allows for analysis linking PBC approaches with client outcomes	• Prone to social desirability bias • Requires high volume of clients to be cost-effective
Provider interviews	• Lower cost • Able to identify individual behavioral determinants that cannot be observed	• Prone to recall and social desirability bias • Can be disruptive of services
Facility assessments	• Captures support, access to professional development, and workplace environment	• Primarily assess drivers of provider behavior but not the actual behavior



How to Measure PBC Impact

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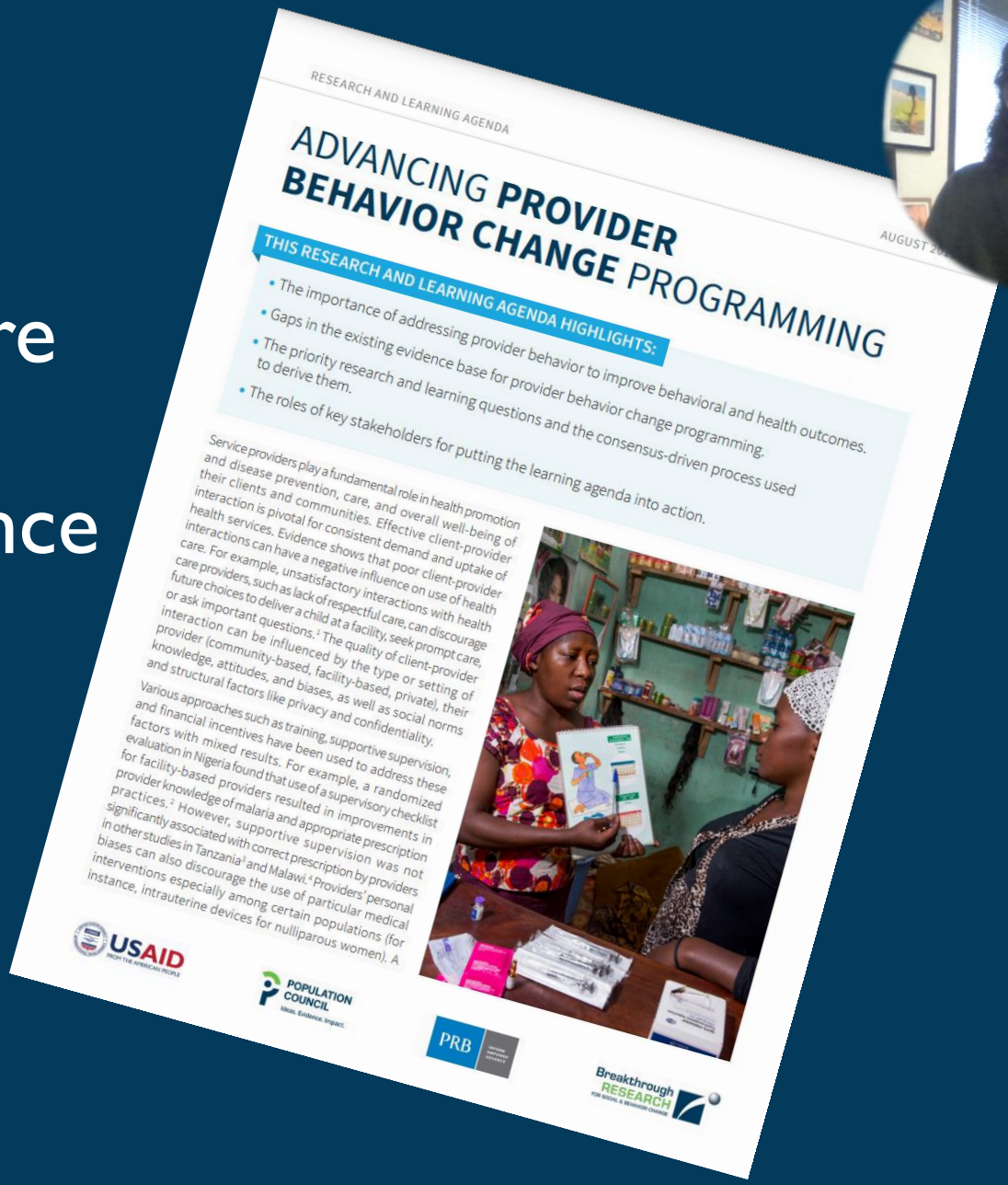
Provider Attitudes

How can we best measure provider attitudes that influence their performance and adherence to timely and respectful client-centered care practices?



Conceptual framework guiding analysis

- Core beliefs
- Local values and norms
- Empathy for clients
- Socialization
- Training and skill building
- Job conditions (workload)
- Peer relationships and management

Provider attitude → Provider motivations → Provider actions → Client use of services ↔ **Client experience/ satisfaction**

Perceptions of clients

Professional roles

Gender

Adapted from: Tavrow P. Promote or discourage: how providers can influence service use. In: Malarcher S, ed. Social Determinants of Sexual and Reproductive Health: Informing Future Research and Programme Implementation. Geneva: World Health Organization; 2010.

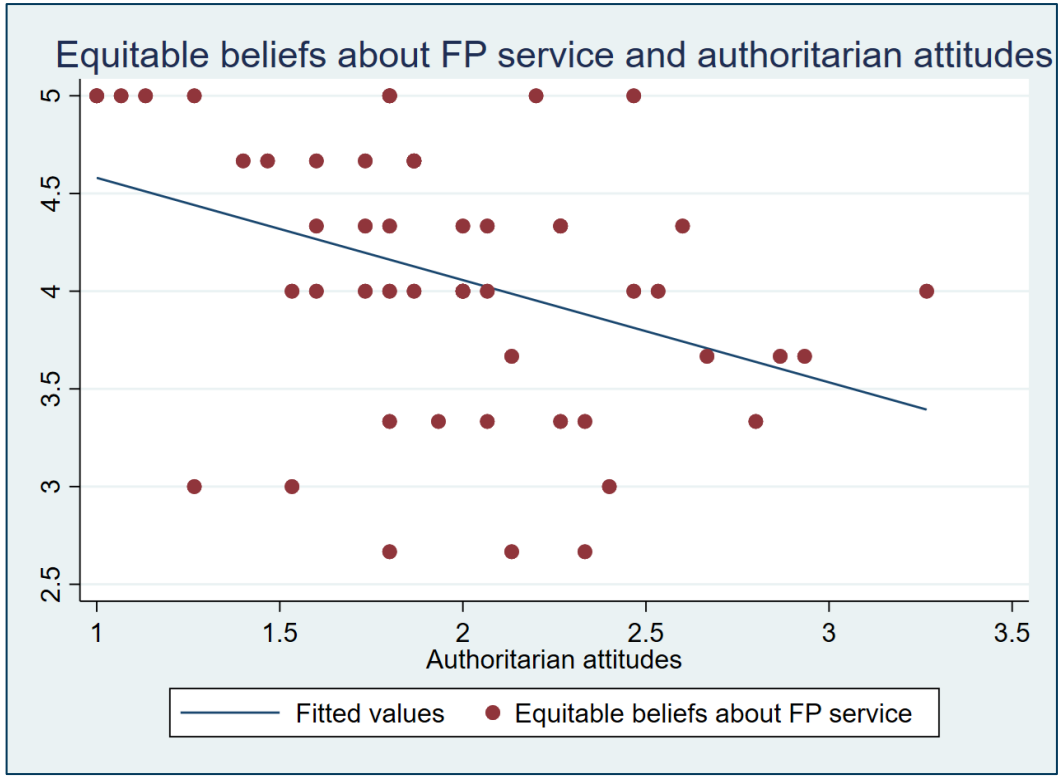
Scale items

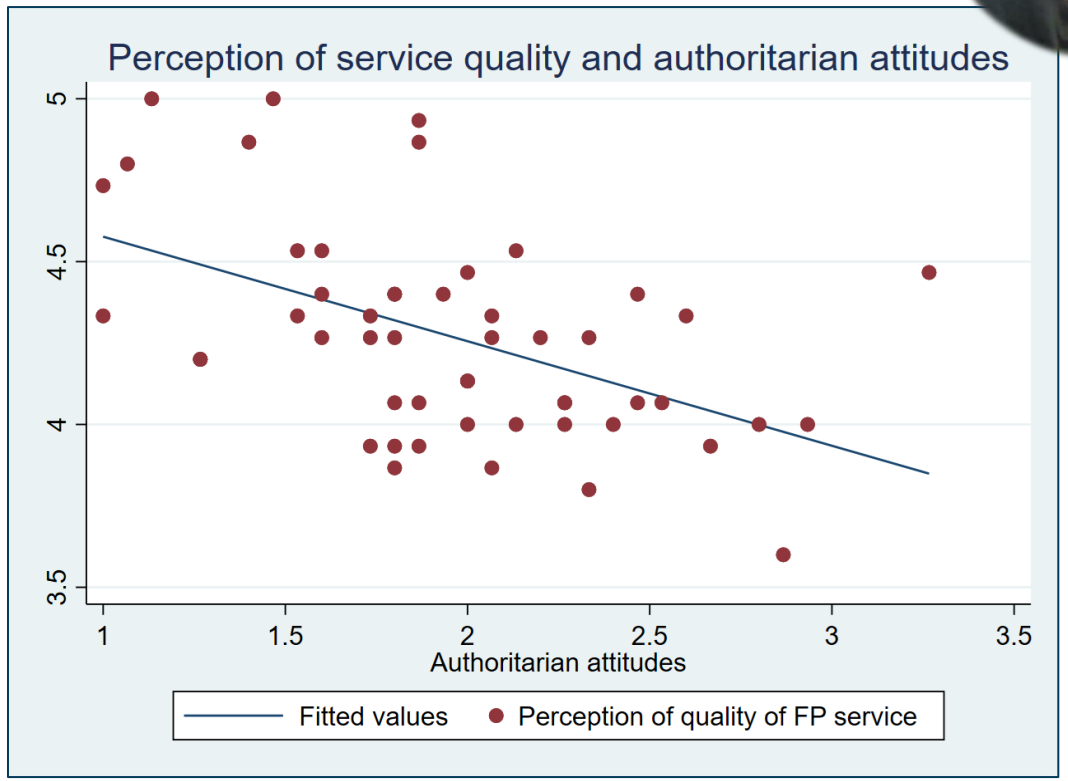
PROVIDER AUTHORITARIAN ATTITUDE SCALE ITEMS

	ENGLISH	FRENCH
1	Patients I care for are not capable of making good health decisions for themselves.	Mes patients dont je m'occupe ne sont pas assez capables pour prendre de bonnes décisions pour leur santé.
2	Patients I care for should appreciate my efforts when I care for them.	es patients doivent apprécier des efforts que je leur fournis quand je m'occupe d'eux.
3*	One should treat patients with respect even if they don't treat me with respect.	Il faut traiter les patients avec respect même s'ils ne me traitent pas avec respect.
4*	Patients must always respect providers, regardless of the quality of care they receive.	Les patients doivent toujours respecter les prestataires, quelle que soit la qualité des soins qu'ils prodiguent.
5*	My patients will put a lot of effort into improving their health if they are given the right information.	Mes patients fourniront beaucoup d'efforts pour améliorer leur santé si on leur donne les bonnes informations.
6	A provider's role is to diagnose patients and provide clinical care, not to teach patients how to improve their health and prevent disease.	Le rôle d'un prestataire est de diagnostiquer les patients et leur fournir des soins cliniques, et non pas d'apprendre aux patients comment améliorer leur santé et prévenir les maladies.
7*	I have the responsibility to ensure that patients have a say in their care.	J'ai la responsabilité de veiller à ce que les patients aient leur mot à dire sur les soins qu'ils reçoivent.
8*	It is important to listen to patients to ensure they understand their care.	Il est important d'écouter les patients pour s'assurer qu'ils comprennent les soins dont ils ont besoin.
9	My role as a provider is to resolve my patients' immediate medical problems, and nothing else.	Mon rôle en tant que prestataire est de résoudre les problèmes médicaux immédiats de mes patients seulement, sans m'occuper d'autre chose.
10*	When medications are given, it is important that I explain well to patients how they work and how it will benefit them.	Lorsque des médicaments sont administrés, il est important que j'explique bien aux patients comment ils agissent et en quoi cela va leur être bénéfique.
11	My job is to diagnose and treat patients, not to be a health educator for each patient.	Mon travail consiste à diagnostiquer et à traiter les patients, pas à être un éducateur de santé pour chaque patient.
12	A man should have the final say on decisions made in his home.	Un homme doit avoir le dernier mot sur les décisions prises chez lui.
13	A woman must obey her husband in everything.	Une femme doit obéir à son mari par rapport à tout.
14*	It is important for men to be present in their children's life, even if he isn't with their mother anymore.	Il est important qu'un père soit présent dans la vie de ses enfants, même s'il n'est plus avec la mère.

- Elements of each of the initial conceptual domains: perceptions about clients, attitudes about providers' professional roles, and attitudes about gender roles
- $\alpha = 0.83$

Associations with other provider-related outcomes

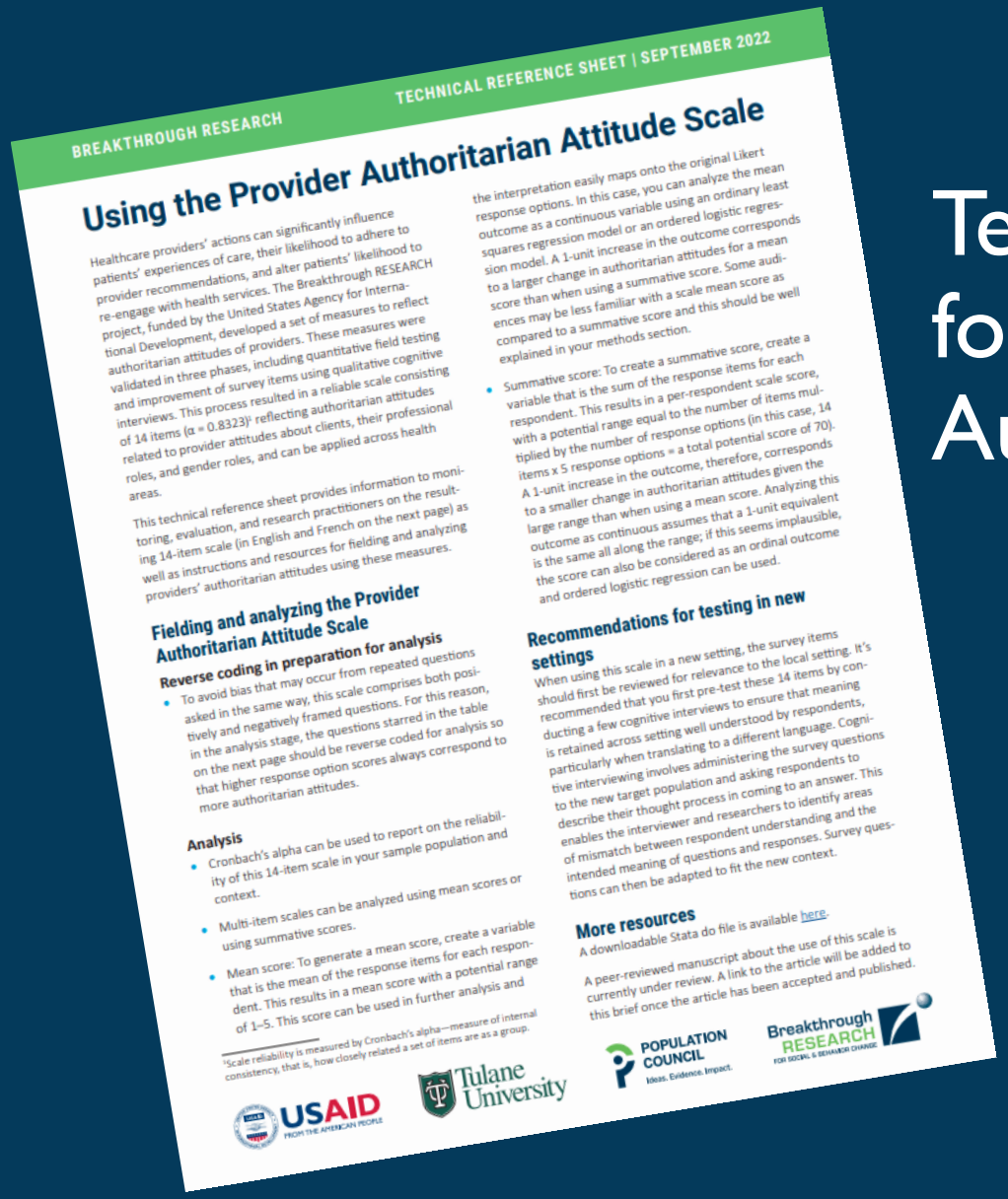




P=.005

P<.001

Adjusted for provider gender, years of experience as a provider and at the facility, training, and managerial status, clustering on health facility.



BREAKTHROUGH RESEARCH

TECHNICAL REFERENCE SHEET | SEPTEMBER 2022

Using the Provider Authoritarian Attitude Scale

Healthcare providers' actions can significantly influence patients' experiences of care, their likelihood to adhere to provider recommendations, and alter patients' likelihood to re-engage with health services. The Breakthrough RESEARCH project, funded by the United States Agency for International Development, developed a set of measures to reflect authoritarian attitudes of providers. These measures were validated in three phases, including quantitative field testing and improvement of survey items using qualitative cognitive interviews. This process resulted in a reliable scale consisting of 14 items ($\alpha = 0.8323$)[1] reflecting authoritarian attitudes related to provider attitudes about clients, their professional roles, and gender roles, and can be applied across health areas.

This technical reference sheet provides information to monitoring, evaluation, and research practitioners on the resulting 14-item scale (in English and French on the next page) as well as instructions and resources for fielding and analyzing providers' authoritarian attitudes using these measures.

Fielding and analyzing the Provider Authoritarian Attitude Scale

Reverse coding in preparation for analysis

- To avoid bias that may occur from repeated questions asked in the same way, this scale comprises both positively and negatively framed questions. For this reason, in the analysis stage, the questions starred in the table on the next page should be reverse coded for analysis so that higher response option scores always correspond to more authoritarian attitudes.

Analysis

- Cronbach's alpha can be used to report on the reliability of this 14-item scale in your sample population and context.
- Multi-item scales can be analyzed using mean scores or using summative scores.
- Mean score: To generate a mean score, create a variable that is the mean of the response items for each respondent. This results in a mean score with a potential range of 1–5. This score can be used in further analysis and the interpretation easily maps onto the original Likert response options. In this case, you can analyze the mean outcome as a continuous variable using an ordinary least squares regression model or an ordered logistic regression model. A 1-unit increase in the outcome corresponds to a larger change in authoritarian attitudes for a mean score than when using a summative score. Some audiences may be less familiar with a scale mean score as compared to a summative score and this should be well explained in your methods section.
- Summative score: To create a summative score, create a variable that is the sum of the response items for each respondent. This results in a per-respondent scale score, with a potential range equal to the number of items multiplied by the number of response options (in this case, 14 items x 5 response options = a total potential score of 70). A 1-unit increase in the outcome, therefore, corresponds to a smaller change in authoritarian attitudes given the large range than when using a mean score. Analyzing this outcome as continuous assumes that a 1-unit equivalent is the same all along the range; if this seems implausible, the score can also be considered as an ordinal outcome and ordered logistic regression can be used.

Recommendations for testing in new settings

When using this scale in a new setting, the survey items should first be reviewed for relevance to the local setting. It's recommended that you first pre-test these 14 items by conducting a few cognitive interviews to ensure that meaning is retained across setting well understood by respondents, particularly when translating to a different language. Cognitive interviewing involves administering the survey questions to the new target population and asking respondents to describe their thought process in coming to an answer. This enables the interviewer and researchers to identify areas of mismatch between respondent understanding and the intended meaning of questions and responses. Survey questions can then be adapted to fit the new context.

More resources

A downloadable Stata do file is available here.

A peer-reviewed manuscript about the use of this scale is currently under review. A link to the article will be added to this brief once the article has been accepted and published.

[1] Scale reliability is measured by Cronbach's alpha—measure of internal consistency, that is, how closely related a set of items are as a group.

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Technical Reference Sheet for Using the Provider Authoritarian Attitude Scale

Mentimeter

Go to www.menti.com and use the code 5865 7498

Mentimeter

Instructions

Go to

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Research Spotlights on PBC

Research spotlights

Breakthrough RESEARCH worked with SBC implementing partners to develop a series of interactive research spotlights that:

- Demonstrate how priority questions outlined in the RLAs are being answered to improve programming.
- Share tools and resources for partners.
- Raise the visibility of current technical work.

What priority RLA questions did Beyond Bias answer and how?

EVIDENCE GENERATION		PROGRAM DESIGN
RLA Question Answered: *What are the underlying drivers that shape provider behavior in interpersonal communication with clients?*	**RLA Question Answered:** *How do the underlying drivers shape provider profiles?*	**RLA Question Answered:** *Which interventions are most important to improving the quality of provider counseling?*
Literature Review and Expert Interviews → Provider Bias Driver Tree	Survey Segmentation and Analysis → Provider Profiles and Classification Tool	Ideation → Rough Prototyping → Live Prototyping → Final Solution

Provider Bias Driver Tree

CATEGORY	SUB-CATEGORY	DRIVER	SUB-DRIVERS/DETAILS
BIOGRAPHIC	Attitudes	Negative attitudes	Perception of youth as reckless, dangerous, "bad"; Power dynamics and a perceived role of superiority
		Willingness to change	Set in old modes of thinking and serving clients
	Abilities	Communication	Ability and comfort communicating with youth
		Bias recognition	Ability to recognize and manage existing bias toward youth
	Experience	Product (in)experience	Specific negative/positive product experience; Lack of experience with specific products
		Client experience	Lack of familiarity or capability working with youth; Fear of interacting with youth
	Knowledge	Limited knowledge	Lack of adolescent and youth SRH training; Lack of training/familiarity on certain family planning methods
		Misinformation	Outdated or incorrectly applied guidance; Misinfomration about specific products
SITUATIONAL	Professional	Workload	Too busy to provide quality care, especially to youth
		Incentives (financial)	Not incentivized to work with youth due to low profitability
		Workplace norms	Accepted attitudes toward and approach to serving youth
		Clinic reputation	Fear of integrating family planning youth services into programming
		Product availability	Restrictive distribution practices; Selective distribution incentives (e.g. excess inventory)
		Competing SRH risks	Concern of HIV or other STI transmission
	Social	Community hierarchy	Perceived/actual position as figures of authority
		Geographic displacment	Outside geographic comfort region
SOCIETAL	Beliefs/norms	Religion	Youth sexuality is immoral; Stigma against spacing, modern methods, family planning generally
		Pessimism	May have limited hope for youth—family planning doesn't matter
		Social norms	Social stigma (non-religious) against youth having sex; Childbearing, marriage, and fertility expectations
	Law/policy	Law/community justice	May not feel fully legally protected in providing adolescent and youth reproductive health services; May fear extra-legal reprisals or consequences

Camber Collective. 2018. Beyond Bias: Provider Survey and Segmentation Findings.

Links to available resources throughout the spotlight

surgo.prb.org

MENU

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DECEMBER 2021
A RESEARCH SPOTLIGHT FROM BREAKTHROUGH RESEARCH

Surgo Ventures' CUBES Framework

Understanding Drivers of Behavior to Develop a Tailored Approach to Social and Behavior Change

BACKGROUND FRAMEWORK CASE STUDIES PRINCIPLES RESOURCES

Using the CUBES Framework for PBC

Confident hard workers

25%

High performing with strong support.

Independent high-achievers

18%

High performing with strong support.

Undertrained but motivated

24%

In need of additional clinical training, though are working hard.

Financially troubled and hands-off

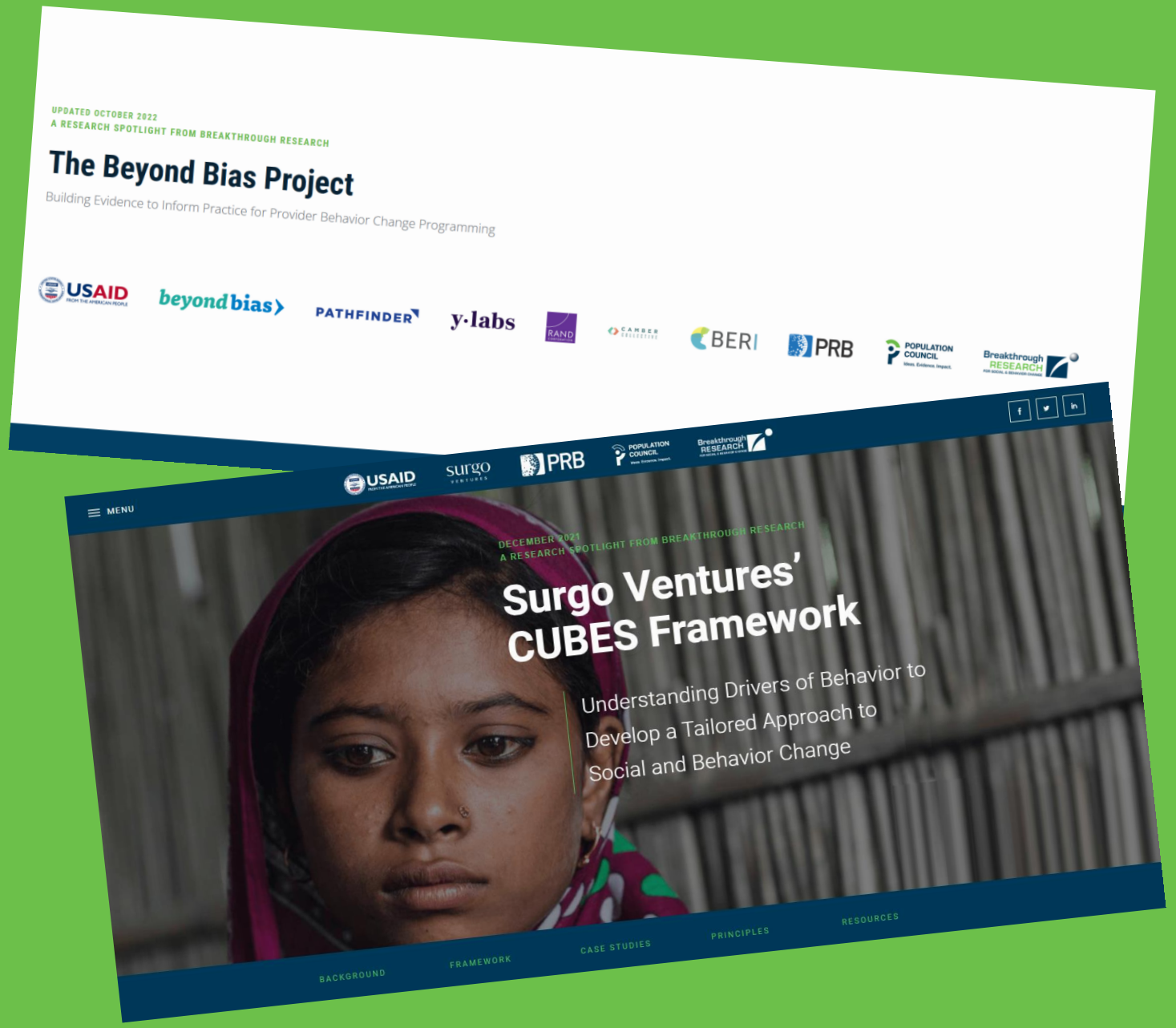
15%

Need support with the incentive payment system.

Struggling traditionalists

18%

Struggles all around - with knowledge, motivation, and support and holds many outdated beliefs - and can only improve through a substantial effort and/or replacement.



Explore the Research Spotlights

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Discussion and Q&A

Call to Action for PBC

Future approaches to improve the quality of family planning services should commit to robust evaluation of PBC interventions to enable comparable learning that supports policy makers to target quality improvement and invest in evidence-based behavior change programs.

Call to action

SBC PROGRAMS: To continue to improve the quality of care of family planning services, program designers should commit to designing interventions that address providers' behavioral determinants—such as attitudes and biases—and are robustly evaluated.

SERVICE DELIVERY PROGRAMS: Program designers should consider SBC approaches as critical evidence-based interventions that can complement other quality of care or service delivery approaches to improve family planning outcomes through the identified promising PBC opportunities.

SBC RESEARCHERS: Future research should develop and validate new measures or adapt and use existing measures, such as the provider authoritarian attitudes scale, to generate a more comparable and standardized evidence base that reflects the complexity and nuance of provider behavior.

DONORS: Donors should commit to investing in evidence-based PBC programs and to requiring their robust evaluation and standardized measurement of provider behavior and its determinants.

What's next for strengthening PBC interventions?

- Consider further testing of *social accountability approaches* to better understand the range of interventions that can effectively be deployed to improve family planning provider behaviors.
- Further research is needed to understand *whether improving the behaviors/practices of family planning providers influences the quality of care provided* and to identify the most effective SBC approaches to improve quality of care.
- Family planning program implementers and researchers should consider *applying both a framework that captures the system level determinants and a behavioral theory that captures individual determinants* to create a more comprehensive picture of the drivers of provider behavior.

What's next for measurement of PBC?

- Moving beyond cross-sectional descriptive studies, beyond assessing skills, and training-based approaches, *measurements of core concepts of family planning provider behavior, such as provider attitudes and provider bias, are needed* to concretely assess and address provider performance.
- Where possible, *behavioral measures and family planning outcomes should be captured* in addition to more intermediate factors, such as changes in knowledge, attitudes, and beliefs, changes in self-efficacy, and changes in social norms that might influence provider behavior.
- Evaluations of PBC interventions should *use a multi-modal data collection approach to collect both provider-level and client-level outcomes* to help elucidate how changing provider behavior is linked with improved client outcomes for family planning.

Coming soon! PBC supplement in *Global Health: Science and Practice*

- **Objective:** Raise the profile of PBC in the global health community and highlight innovations in PBC research, programming, and evaluation, framed by RLA evidence gaps
- Proposes an **operating definition of PBC**; discuss **measurement approaches**; identify **research and programming gaps and opportunities**; present **research and evaluations** related to PBC programming approaches with **recommendations for the future**
- Publishing on a rolling basis; full launch in mid-2023

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Discussion and Q&A

- Please post your questions in the chat.
- We will also discuss the implications from the Mentimeter results we've seen throughout the webinar.


Breakthrough RESEARCH
Legacy and Learning Series
PROVIDER BEHAVIOR CHANGE:
A SOCIAL BEHAVIOR CHANGE APPROACH TO QUALITY OF CARE IN FAMILY PLANNING
JANUARY 2023
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Breakthrough RESEARCH

Join Us For 4 Breakthrough RESEARCH Legacy Webinars

We will reflect on what we have learned over the past 6 years about catalyzing social and behavior change (SBC) in family planning around the world with cutting-edge research and evaluation. Scan the code to access registration links for each webinar. Each webinar will be simultaneously interpreted in French.

Provider Behavior Change and SBC Approaches to Quality of Care in Family Planning
31 Jan 2023

Advancing SBC Measurement for Family Planning
28 Feb 2023

SBC and the Enabling Environment for Family Planning
21 Mar 2023

Costing for Family Planning SBC
19 Apr 2023

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Breakthrough RESEARCH catalyzes social and behavior change (SBC) by conducting state-of-the-art research and evaluation and promoting evidence-based solutions to improve health and development programs around the world. Breakthrough RESEARCH is a consortium led by the Population Council in partnership with Avenir Health, ideas42, Institute for Reproductive Health at Georgetown University, Population Reference Bureau, and Tulane University.

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