

A woman with braided hair, wearing a red dress with a gold pattern, is shaking hands with a man in a blue shirt. They are outdoors in a dirt area with some greenery in the background. The scene is framed by a thin yellow and green border.

BEYOND BIAS

THREE COUNTRY INSIGHTS

beyond bias >



y·labs

**“17 IS A FOOLISH AGE.
IT’S A DISTURBING
STATE OF CONFUSION.
YOUR BODY IS CHANGING.
YOU HAVE PHYSICAL
DESIRES. YOU’LL
MAKE MISTAKES.”**

Provider, Tanzania



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THANK YOU

Thanks to everyone who worked
together to understand youth,
provider and community
perspectives across three countries.

3 COUNTRIES, 3 STORIES



SAIDA, TANZANIA



FARZANA, PAKISTAN



JEAN-BAPTISTE, BURKINA FASO

SAIDA, TANZANIA



SAIDA IS 16 AND LIVES IN ILALA, DAR ES SALAAM.

When I was a little girl, I was told to focus on my studies. But when I became a woman, I was told to focus only on getting married and having children. Growing up shouldn't mean giving up on your dreams. I have a boyfriend, so getting pregnant right now will ruin our futures. I learned about contraception from my older sister, but unlike her, I'm not married. The journey into the clinic was awful - I was judged silently and verbally as I waited for hours. Once I met the provider, I wasn't helped. I was scolded for even thinking of contraception when I haven't had a child yet.

135 PER 1000

ADOLESCENT
FERTILITY RATE¹

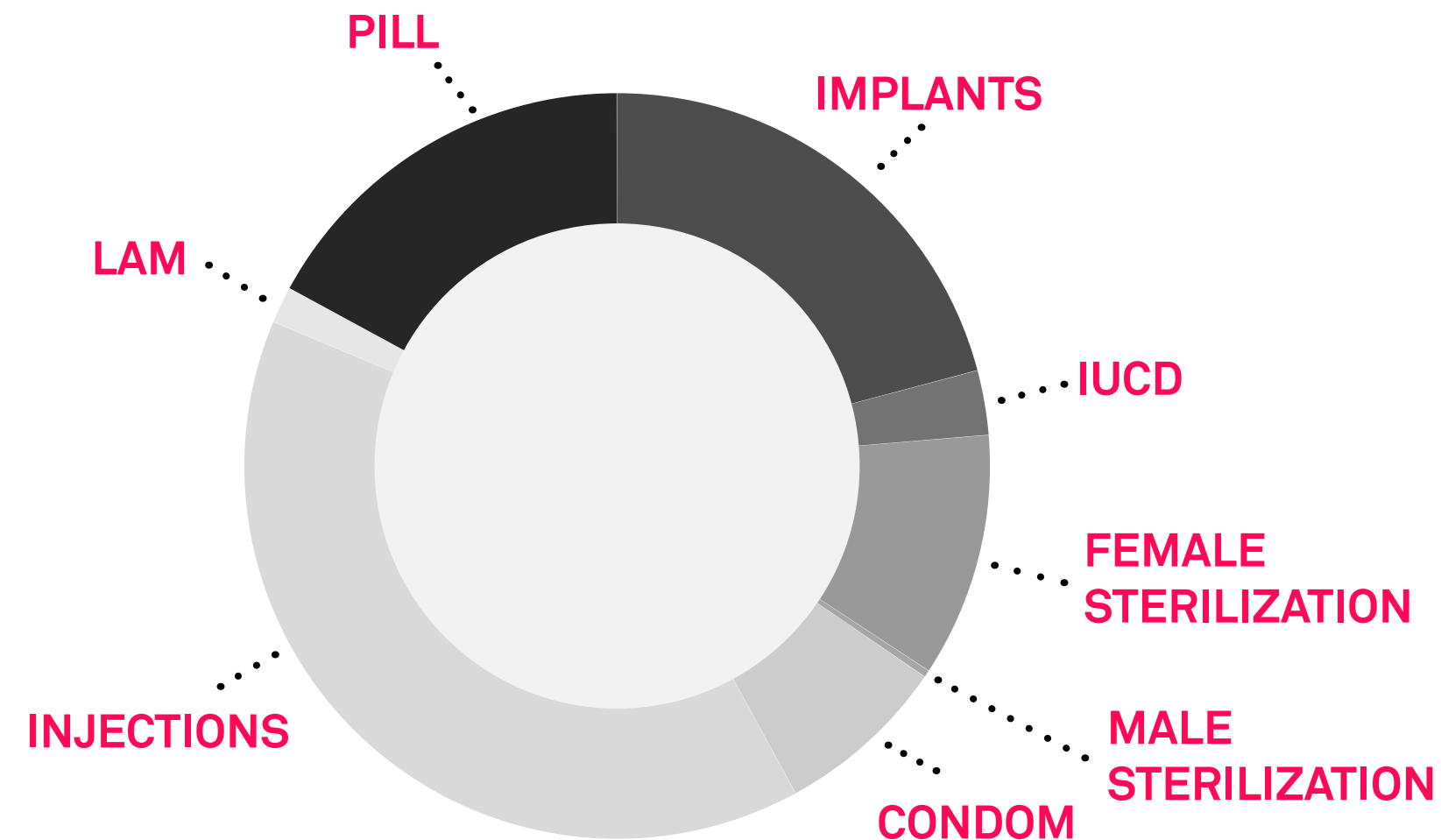
28%

OF WOMEN HAVE GIVEN
BIRTH BY AGE 18²

37%

OF SEXUALLY ACTIVE ADOLESCENTS
(10-19) USED CONDOMS AT LAST SEXUAL
INTERCOURSE³

Tanzania: Policy & Legal Context



**MODERN CONTRACEPTIVE
METHOD MIX, TANZANIA**

“All men and women including young people (10-24 years of age) irrespective of their parity and marital status, are eligible to access accurate, complete family planning information, education and services.”

– National Family Planning Guidelines and Standards, 2013.
Republic of Tanzania

- Clients under 18 can legally access contraception.
- A married teen does not legally need spouse consent to access contraception.
- Tanzanian guidelines specify all modern methods of contraception can be safely used in adolescents

1 FP2020, Data and Measurement Hub: Tanzania, 2017
2 Kazaura MR et al. BMC Public Health. 2009;9:373
3 Exavery A, et al. BMC Public Health. 2011;11:490

**FARZANA,
PAKISTAN**



FARZANA IS 36 AND LIVES AND WORKS IN KARACHI.

My typical day starts early with prayers. My clinic is in my home and I have a lot of family duties to manage before I start work like preparing food and caring for children. My days are busy. Most days I don't eat lunch and I can be called to emergency deliveries day or night. Then I'm dealing with electricity outages, and visitors to my home. Family planning is not a profitable part of my work and sometimes it takes a lot of time. It's especially complicated with these young married women. I feel for these girls - married and having kids at 14 or 15 and having to take care of her husband's household. But we can't give contraception without the mother-in-law's and husband's permission, so we're treating three patients! I'm so well known in this community that I can't afford to take risks, but the community needs to understand why we need to help these girls and protect their health.

“Deaths were common in our village, infants and children did not have access to healthcare services, so from the very start, I always wanted to have my own clinic and serve humanity.”

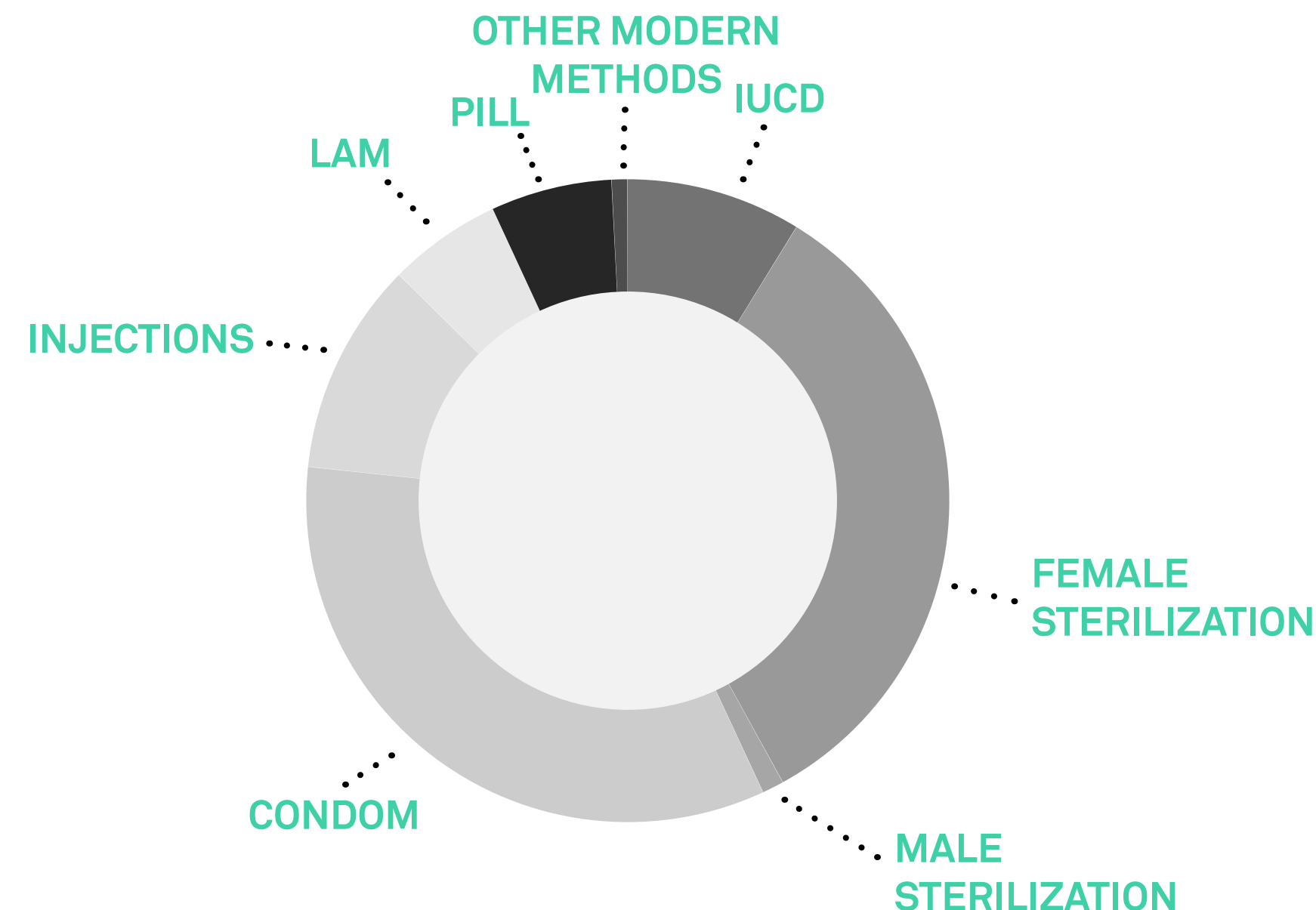
- Provider, Karachi

44 PER 1000
ADOLESCENT
FERTILITY
RATE¹

15%
OF WOMEN HAVE
GIVEN BIRTH BY
AGE 18²

18 MONTHS
IS THE AVERAGE INTERVAL
BETWEEN BIRTHS FOR
WOMEN AGED 15-19²

Pakistan: Policy & Legal Context



**MODERN CONTRACEPTIVE
METHOD MIX, PAKISTAN**

“No person shall be discriminated against in their reproductive lives, in their access to services and information on the grounds of race, color, sex, creed or any other criteria of discrimination.”

– Reproductive Healthcare and Rights Act, 2013.
Government of Pakistan

- Some methods of contraception can be legally obtained without prescription. No age restrictions on EC.³
- Current law permits abortion only to save the woman’s life or to provide “necessary treatment” early in pregnancy.
- The estimated rate of abortions, mostly unsafe and clandestine, doubled between 2002 and 2012.⁴

1 FP2020, Data and Measurement Hub: Pakistan, 2017
2 Demographic and Health Survey, 2012-13
3 International Consortium for Emergency Contraception, 2013
4 Sathar Z et al. Studies in Family Planning 2014 45(4):471-491

ABDOUL, BURKINA FASO



ABDOUL IS A CHIEF IN A VILLAGE JUST OUTSIDE OUAGADOUGOU.

I'm a chief, my father was a chief and my son will be a chief. I have seven healthy children and I make most of my living from our land. I worry about my children growing up in these new times. I no longer know what they are learning in school or from their friends. Technology is changing everything for them - they can see anything on a phone. When they first came talking about family planning in the village, I thought it was a good thing. We work hard and sometimes there's not enough for a big family to eat and keep the children in school. But talking about it with the young ones, before marriage - it's wrong. At that age they are not ready and they should be learning how to live a proper life, not engaging in sex, getting pregnant and shaming their parents. We should educate them the right way.

"No marriage, no talk about sex, only marriage gives the permission to talk about sex and have sex to have children."

- Community Member, Bobo-Dioulasso

147 PER 1000

ADOLESCENT
FERTILITY RATE¹

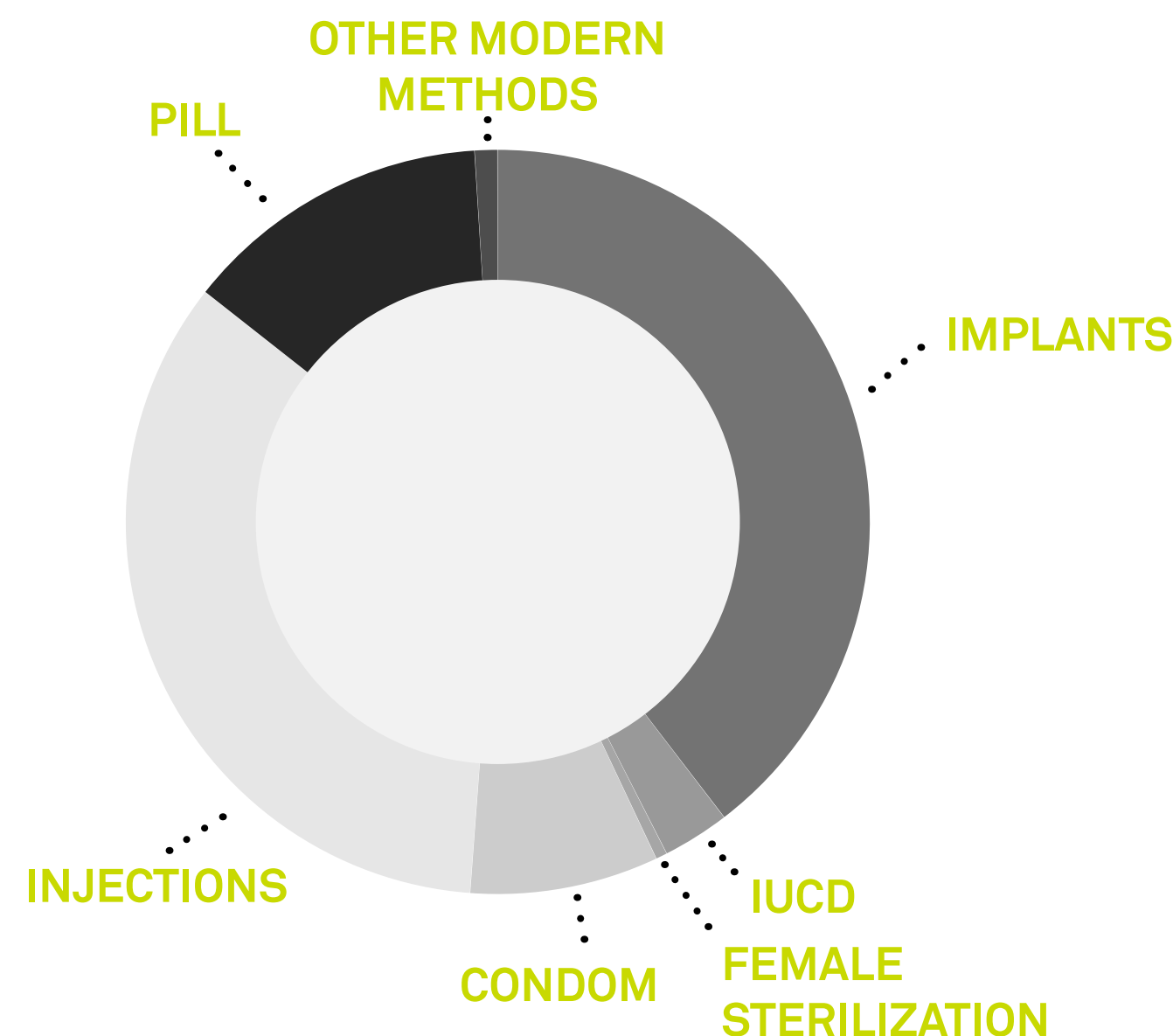
25%

OF WOMEN HAVE
GIVEN BIRTH BY
AGE 18²

42%

OF GIRLS ARE MARRIED
BEFORE AGE 18³

Burkina Faso: Policy & Legal Context



**MODERN CONTRACEPTIVE
METHOD MIX, BURKINA FASO**

“Every person of reproductive age has the right to family planning services. Everybody has the right to information on reproductive health.”

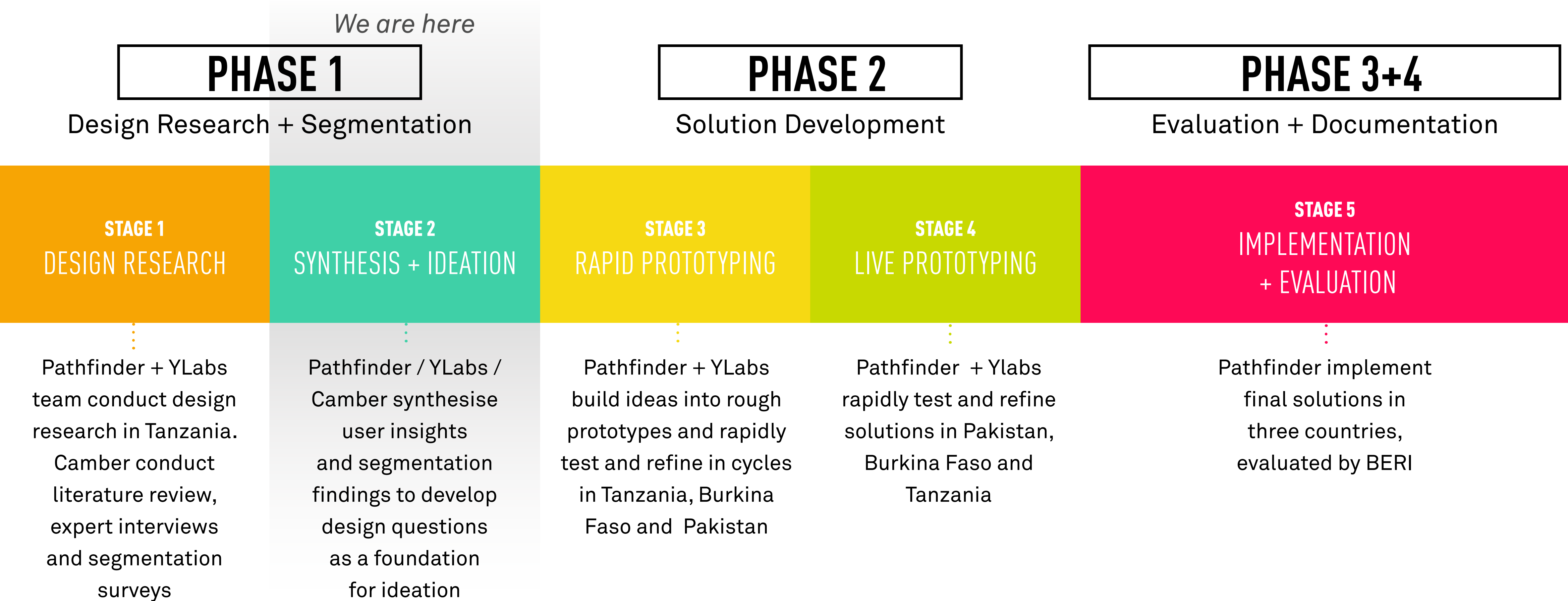
– National Policy on Reproductive Health, 2010 Ministry of Health, Burkina Faso

- Burkina Faso has one of the highest fertility rates in the world, with 5.7 children per woman.
- The national family planning plan commits to educating young people about contraception.⁴
- National policy lists contraception as a required health service for youth (10-24 years).^{5,6}

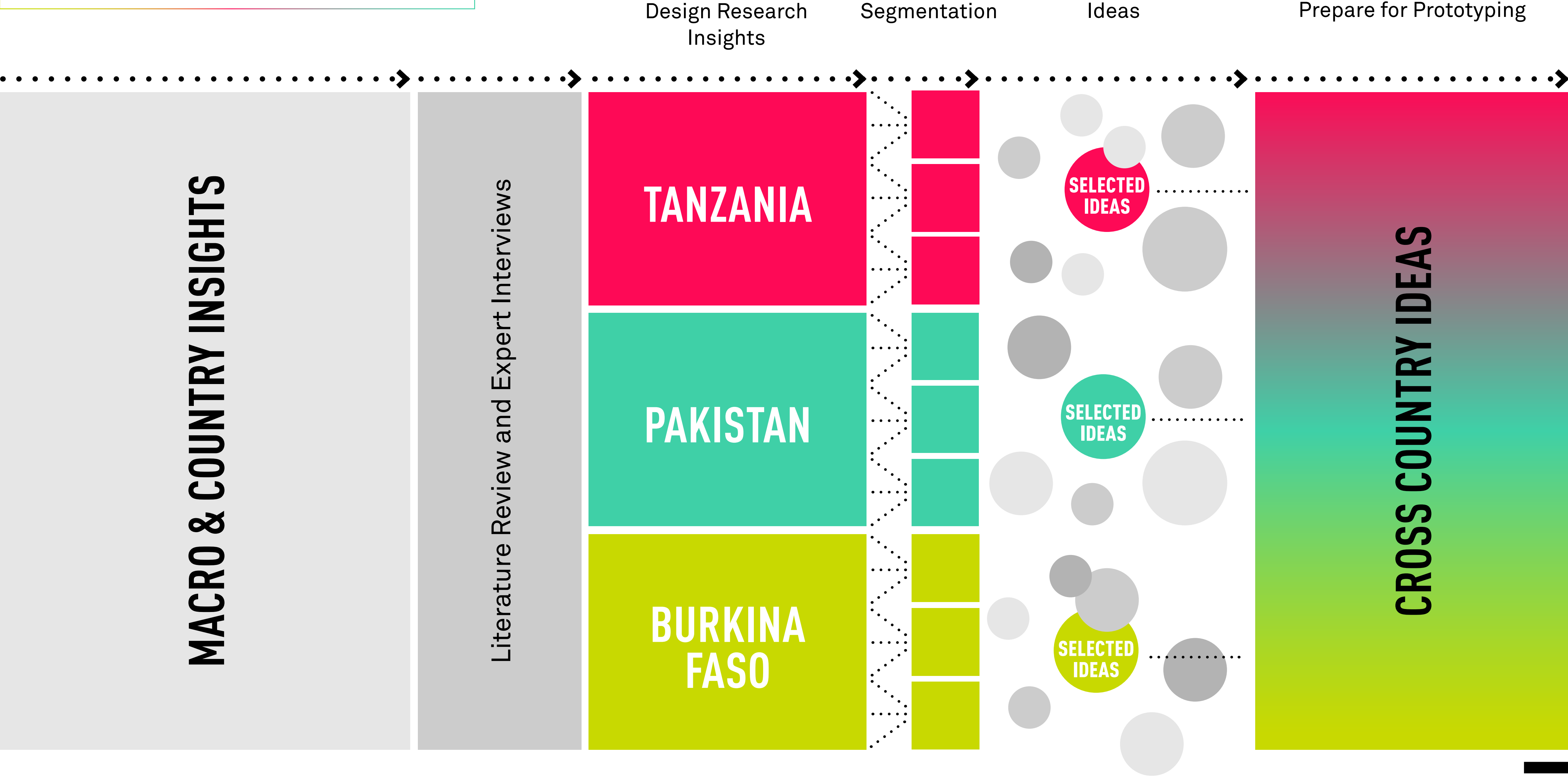
1 FP2020, Data and Measurement Hub: Burkina Faso, 2017
2 World Bank. Basic profile of early childbirth in Burkina Faso, 2016
2 Guttmacher Institute. 2015
4 National Plan for Relaunch of Family Planning, 2013 Ministry of Health, Burkina Faso
5 Reproductive Health Protocols, 2010. Ministry of Health, Burkina Faso
6 National Policy on Reproductive Health, 2010 Ministry of Health, Burkina Faso
7 Law Number 049-2005/AN Portant Santé de la Reproduction, 2005

Project Overview

METHODOLOGY OVERVIEW



OUTPUTS OF DESIGN RESEARCH



OBJECTIVES OF THIS PHASE

1. To conduct design research in Tanzania, Pakistan and Burkina Faso with providers, youth and community stakeholders
2. To build capacity among the Pathfinder team in conducting design research

WHAT WE KNEW

Prior to design research, Camber Collective conducted a literature review on provider bias and compiled data from expert interviews.

We define provider bias as judgmental, non-empathetic, and/or low-quality provider behaviors targeted to a specific client subset, that compromises client health outcomes.

Key Findings

SOCIETAL OR COMMUNITY ATTITUDES DRIVE MOST DOCUMENTED PROVIDER BIAS, THE MOST PREVALENT BEING EXPECTATIONS FOR:

1. Young people to abstain from sexual activity before marriage
2. Young, married women to bear children and ‘prove’ fertility

THE MOST CONSISTENT DRIVERS OF PROVIDER BIAS WERE:

- Lack of understanding and poor communication in provider-youth interactions
- Disincentives to work with adolescents, who require more time and sensitivity
- Incorrect guidance on side effects and fertility risks of contraception for youth, particularly for long-acting hormonal methods
- An empathetic, protective, parental attitude can lead to discrimination against youth
- Heavy workload and stress may exacerbate existing biases
- Bias exists on a spectrum, and our understanding needs to take into account the severity of bias and the repercussions for youth

CLIENT CHARACTERISTICS

- Young clients’ appearance, maturity, intelligence as well as age, education level, gender, marital status can exacerbate or ameliorate the bias drivers in providers
- Young clients prioritize confidentiality and privacy in clinical settings
- Youth often want adult involvement in critical decision making, which might violate their own general desires for privacy and independence

RESEARCH QUESTIONS

- What are provider, youth and community perspectives on providing sexual and reproductive health (SRH) services to adolescents?
- What are the social, economic, and technological contexts that influence attitudes, behaviors and decision making among providers?
- How does environment, education, activities and influencers including social norms, peer providers, family, social media, and religion affect provider and youth decision making?

Methodology

PARTICIPANT PROFILE



154
YOUTH &
VULNERABLE ADULTS

— *Participants were recruited by Pathfinder teams with a focus on providers who offer contraceptive services. All participants gave informed consent to take part. All photos are used with consent.*

Included:

- Young men and women
- Married and unmarried
- With children and without children
- In-school and out-of-school
- Marginalized groups eg. 10 sex workers were interviewed in Pakistan



163
PROVIDERS & ALLIED STAFF

- Staff with diverse training (e.g. medical officer, nurse, receptionist, CHW)
- Public, private for profit and non-profit clinics
- Staff with varied levels of training in youth friendly services



56
COMMUNITY INFLUENCERS
& EXPERTS

- Community influencers from both rural and urban settings
- Included health service administrators, technical experts, national government officials, religious leaders, teachers, village chiefs and city government officials

DESIGN RESEARCH: LOCATIONS

Our teams worked together to conduct design research in three countries from March to July, 2017. Locations were selected primarily in urban and peri-urban areas in Pakistan and Tanzania with some rural sites in Burkina Faso. A subset of clinics were purposively selected to participate in co-design workshops and will be potential sites for future prototyping.

PAKISTAN KARACHI

- 40 providers
- 15 community mobilizers
- 43 youth & other clients
- 15 community influencers
- 3 technical experts

BURKINA FASO BOBO-DIOULASSO & OUAGADOUGOU

- 54 youth
- 48 providers
- 18 community influencers

TANZANIA DAR ES SALAAM

- 50 youth
- 60 providers
- 20 community influencers

DESIGN RESEARCH: METHODS



IN-DEPTH INTERVIEWS



FOCUS DISCUSSIONS



YOUTH ROLE-PLAY



MYSTERY CLIENTS



CO-DESIGN WORKSHOPS



JOURNEY MAPPING

TRAINING IN HUMAN-CENTERED DESIGN

One of our goals was to build understanding of the HCD process among the Pathfinder teams, as well as confidence and competence to conduct design research, synthesis and insight development with youth and providers.



HCD WORKSHOPS

What we did

- Introductory workshop, USA
- Design research workshops
- Co-Design workshops
- Synthesis workshops



IN-PERSON COACHING

What we did

- One-to-one support during research activities
- Detailed debrief and reflection sessions



REMOTE SUPPORT

What we did

- Preparation with all country teams
- Research packs and materials describing process and activities
- Remote support to Pakistan team
- Follow-up support to prepare for ideation sessions in country

Who are our users?

PERSONAS

Tanzania

PRISCA



“I don’t know what’s happening with my body, and I don’t know who to talk to.”

PROFILE

AGE: 14

GENDER: Female

MARITAL STATUS: Single, unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION:

Secondary school student

NEEDS: Information on body changes and menstruation.

HOLO



“When you’re denied help over and over, you give up on asking for help at all.”

PROFILE

AGE: 17

GENDER: Female

MARITAL STATUS: Single, unmarried

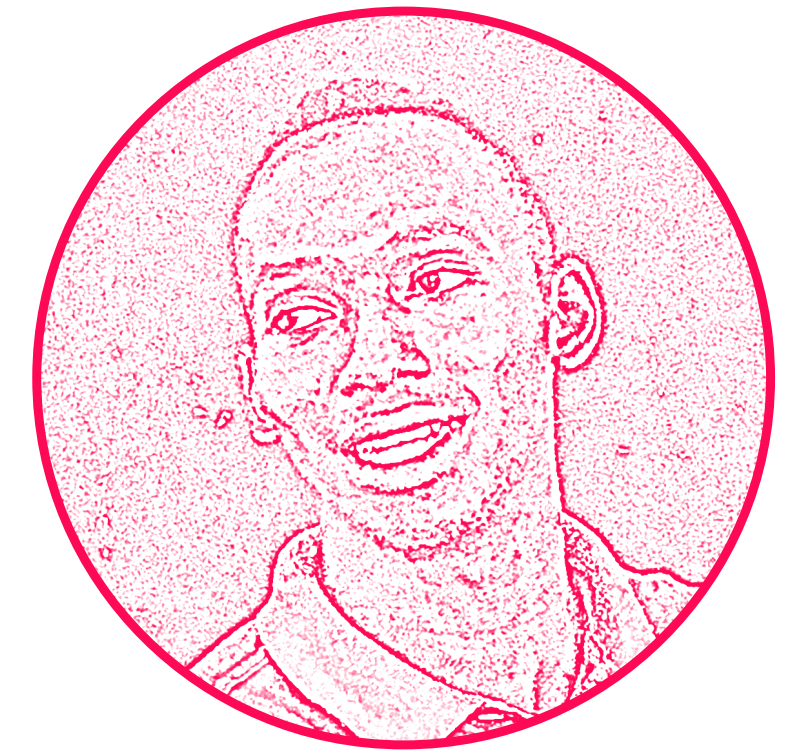
NO OF CHILDREN: 1

OCCUPATION & EDUCATION:

Small bites / snack seller, secondary school drop-out

NEEDS: Long-term acting contraception (IUCD) in order to avoid unwanted pregnancy, so that her educational aspirations will not be compromised.

CHRIS



“Where are we supposed to learn more? I can’t trust the internet and my friends don’t know much more than me. I don’t want a baby at my age.”

PROFILE

AGE: 17

GENDER: Male

MARITAL STATUS: Single, unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION: Student

NEEDS: Access to SRH information. Support his girlfriend in getting contraceptive services.

PERSONAS

Pakistan

FARWA



“When a woman who isn’t ready has a child, it’s not a blessing to the one giving birth and the one who’s been born. Children should be born out of love. Not out of societal conventions or familial obligations.”

PROFILE

AGE: 25

GENDER: Female

MARITAL STATUS: Single, unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION:

University student, BA

NEEDS: Long-acting contraception (IUCD) in order to avoid unwanted pregnancy, and achieve her educational aspirations

MADEEHA



“I wasn’t supposed to go to the clinic without my husband or mother-in-law. But I knew they would refuse to accompany me. So, I went alone, but was still denied. It’s risky for me, but I need to protect my dreams.”

PROFILE

AGE: 21

GENDER: Female

MARITAL STATUS: Newly married (6 months)

NO OF CHILDREN: 0

OCCUPATION & EDUCATION:

Housewife, intermediate

NEEDS: Delay pregnancy to go to university

MARIAM



“I want to be a good mother who can give the best quality of life to my children. But the more children I have, the harder things will be for my family.”

PROFILE

AGE: 22

GENDER: Female

MARITAL STATUS: Married

NO OF CHILDREN: 4

OCCUPATION & EDUCATION:

Housewife, uneducated

NEEDS: Long acting method to avoid unplanned pregnancy, since she doesn’t want to have any more children.

PERSONAS

Burkina Faso

CEDRIC



“I love her, so I’m going to protect her. I’m not going to jeopardize both of our futures by making us parents when we’re not ready.”

PROFILE

AGE: 20

GENDER: Male

MARITAL STATUS: Unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION: University student

NEEDS: Help his girlfriend acquire a long-acting contraceptive method so that they may avoid unwanted pregnancy while both attending university

ALIMA



“Why doesn’t our community see what can happen when a woman is denied contraception? Don’t they see how they’re doing more harm than good?”

PROFILE

AGE: 17

GENDER: Female

MARITAL STATUS: Single, unmarried

NO OF CHILDREN: 1

OCCUPATION & EDUCATION:

School dropout, fruit seller

NEEDS: Long acting contraceptive method to avoid any more future unexpected pregnancies

SARATA



“All my friends said it’s a waste of time to go to a clinic. Providers won’t help girls like us. I still needed to see for myself. My friends were right.”

PROFILE

AGE: 21

GENDER: Female

MARITAL STATUS: Single, unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION: University student

NEEDS: Long term contraceptive method while focusing on education and pursuing career

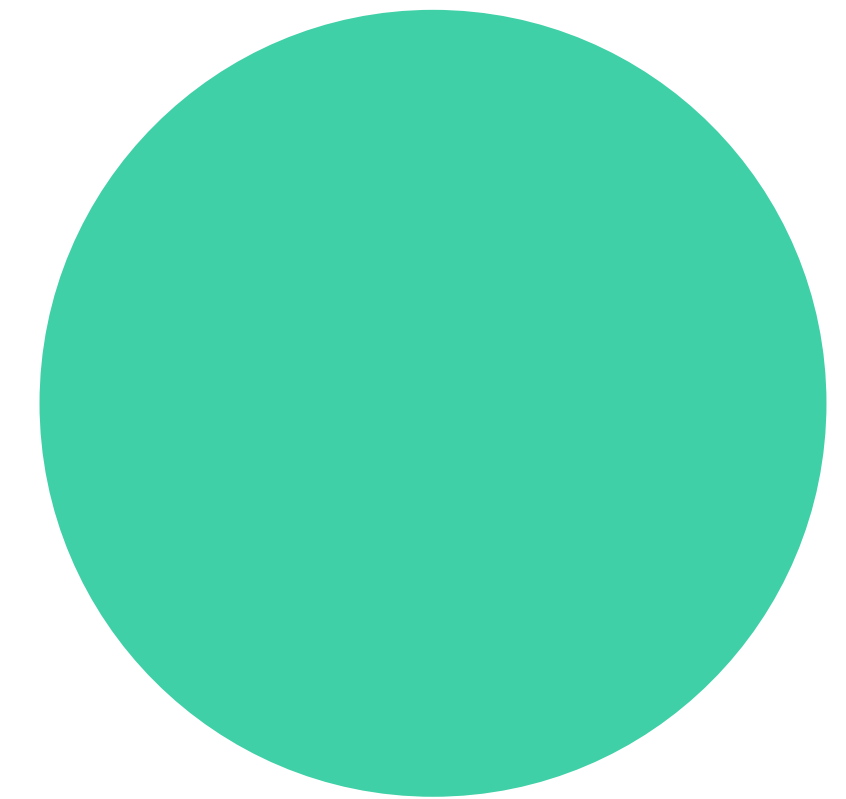
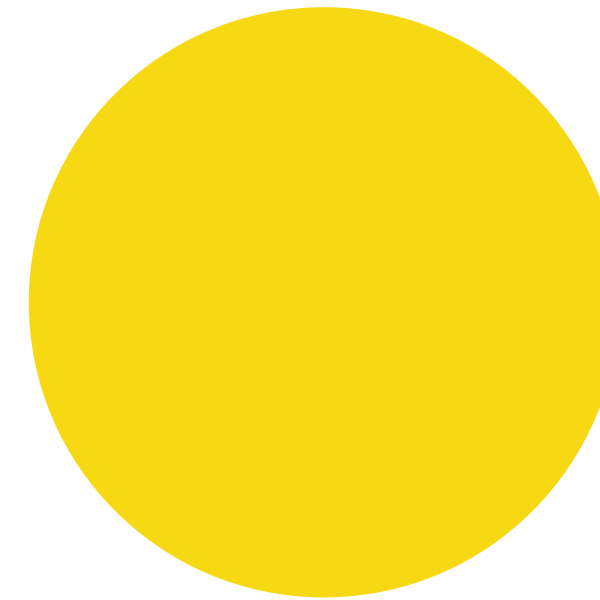
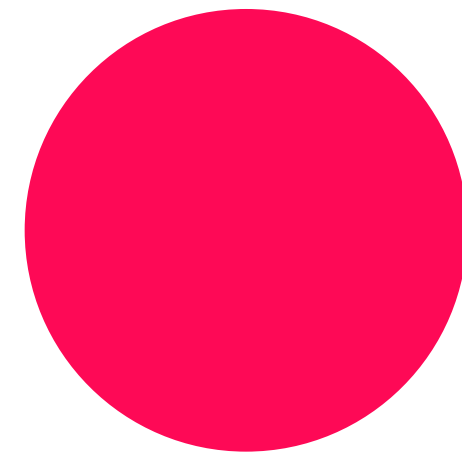
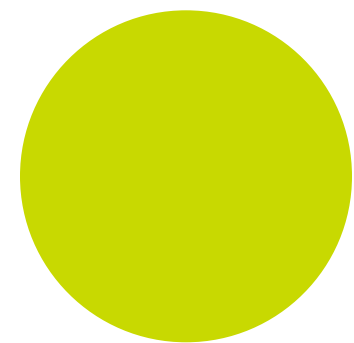
DOMAINS OF INFLUENCE

System
Community
Youth
Provider



What drives provider bias towards youth?
Here are the common themes that we identified from our design research in Tanzania, Pakistan and Burkina Faso

Drivers Of Behavior & Bias: Providers



PROVIDER/FACILITY RELATED

- Multiple providers per room
- Conflicting opinions from peer providers
- Low confidence in giving method, especially LARC
- Demographics: age, sex, type of provider
- Barriers to consent:
 - Need for marriage certificate or identity card
 - Need for family / spouse consent

YOUTH RELATED

- Youth not seen as valuable clients
- Playing parental/protective role
 - Protect client from risk, promiscuity and shame
 - Protect client's fertility
 - Prevent HIV among youth
- Youth have little power to hold them accountable
- Longer time to counsel

COMMUNITY

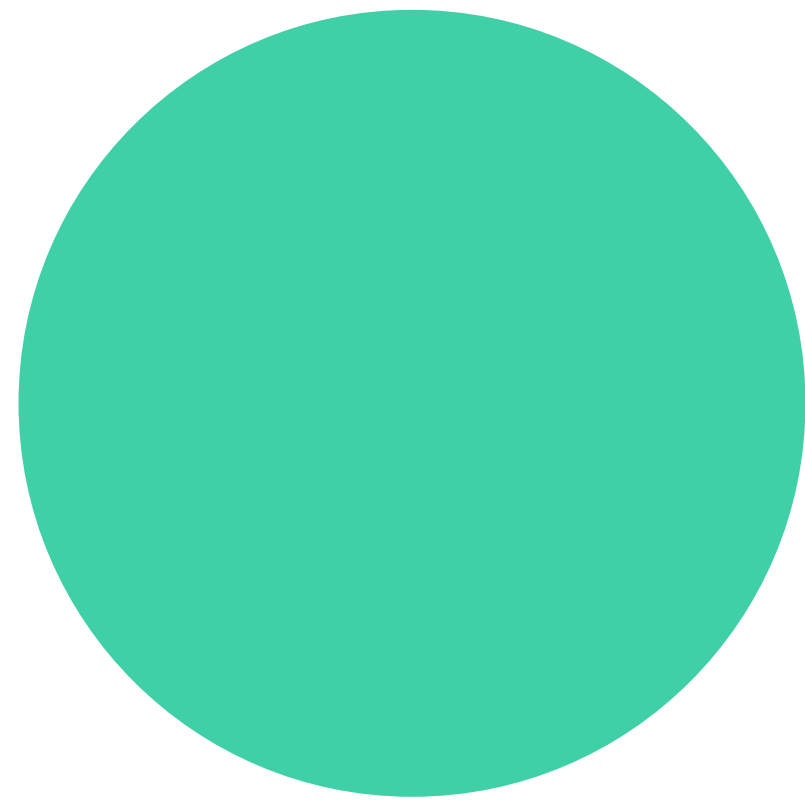
- Stigma of sex or contraceptive use before marriage
- Expectations and norms about timing of marriage/childbirth
- Expectation of woman's reproductive role
- Fear of community and family backlash
- Serve community to improve health
- Male child preference

STRUCTURAL / HEALTH SYSTEM

- High workload
- Shortage of commodities
- Competing priorities or targets
- Lack of incentives/low profit for SRH services
- Lack of accountability for quality
- Lack of training in youth-friendly services
- Lack of supportive policy or legal context
- Confusion about law and policy for youth

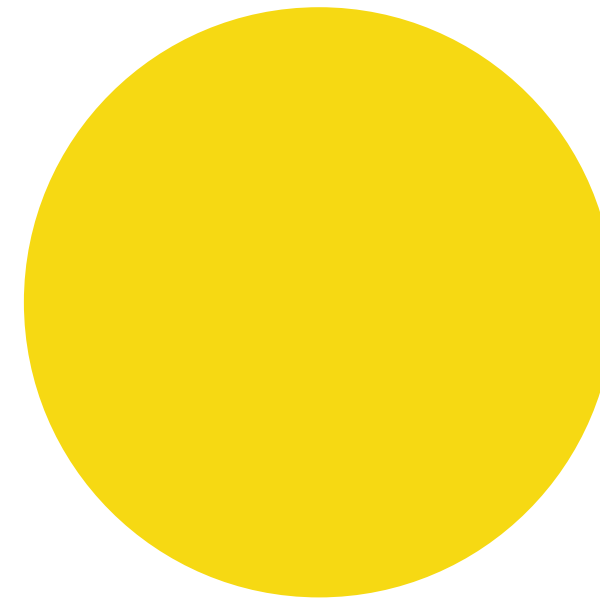
What drives youth behavior and perceptions regarding sexual and reproductive services?

Drivers Of Behavior & Bias: Youth



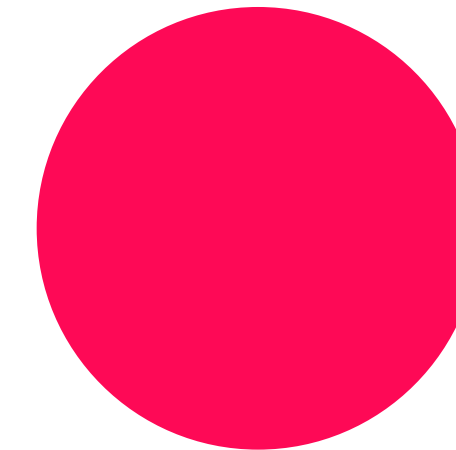
STRUCTURAL / HEALTH SYSTEM

- Services are unaffordable
- Youth are unaware of their rights to access information and services
- Lack of CSE in schools
- Few 'safe' sources of information
- Lack of safe, legal access to abortion



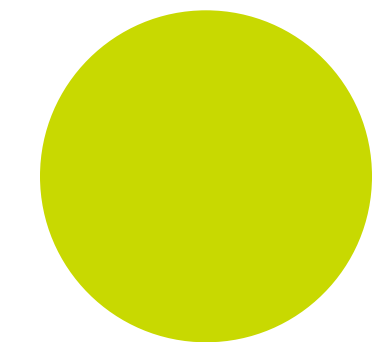
COMMUNITY

- Stigma of sex or contraceptive use before marriage
- Fear of community and family backlash
- Expectations and norms about timing of marriage/childbirth
- Expectation of woman's reproductive role
- Lack of agency and autonomy to make decisions
- Little information from parents or extended family



YOUTH RELATED

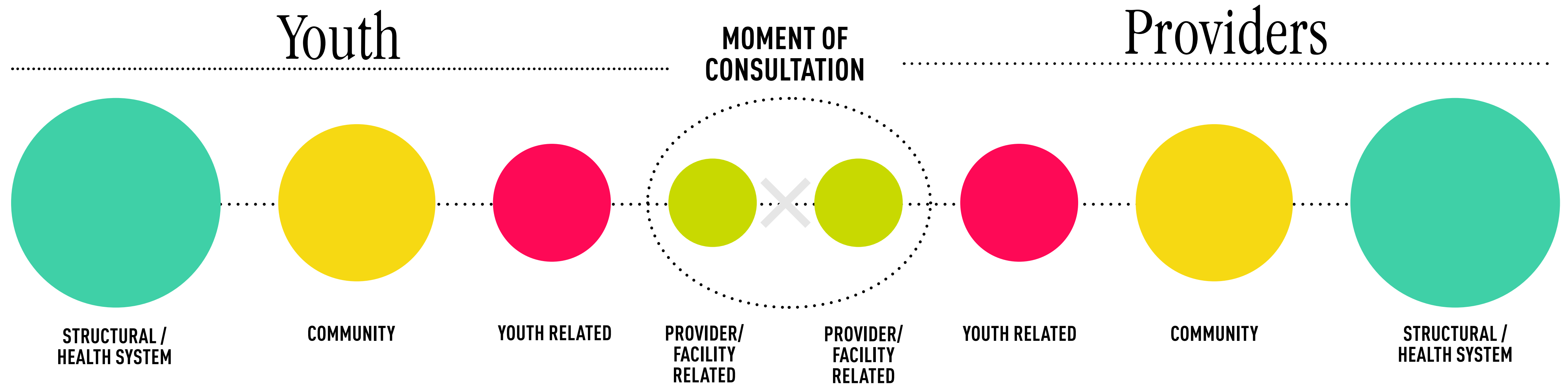
- Negative stories from peers
- Fear of stigma or shaming from peers for visiting clinic or using contraception
- Lack of experience making decisions
- Use of social media and internet to find and share information
- Lack of confidence to ask questions of providers
- Lack of economic independence



PROVIDER/FACILITY RELATED

- Lack of confidentiality and privacy
- Unfriendly and judgmental staff
- Fear of being seen waiting
- Difficulty navigating clinic
- Inadequate opening hours
- Information overload
- Refusal of chosen method
- Demographics: age, sex, type of provider
- Coercion or abuse

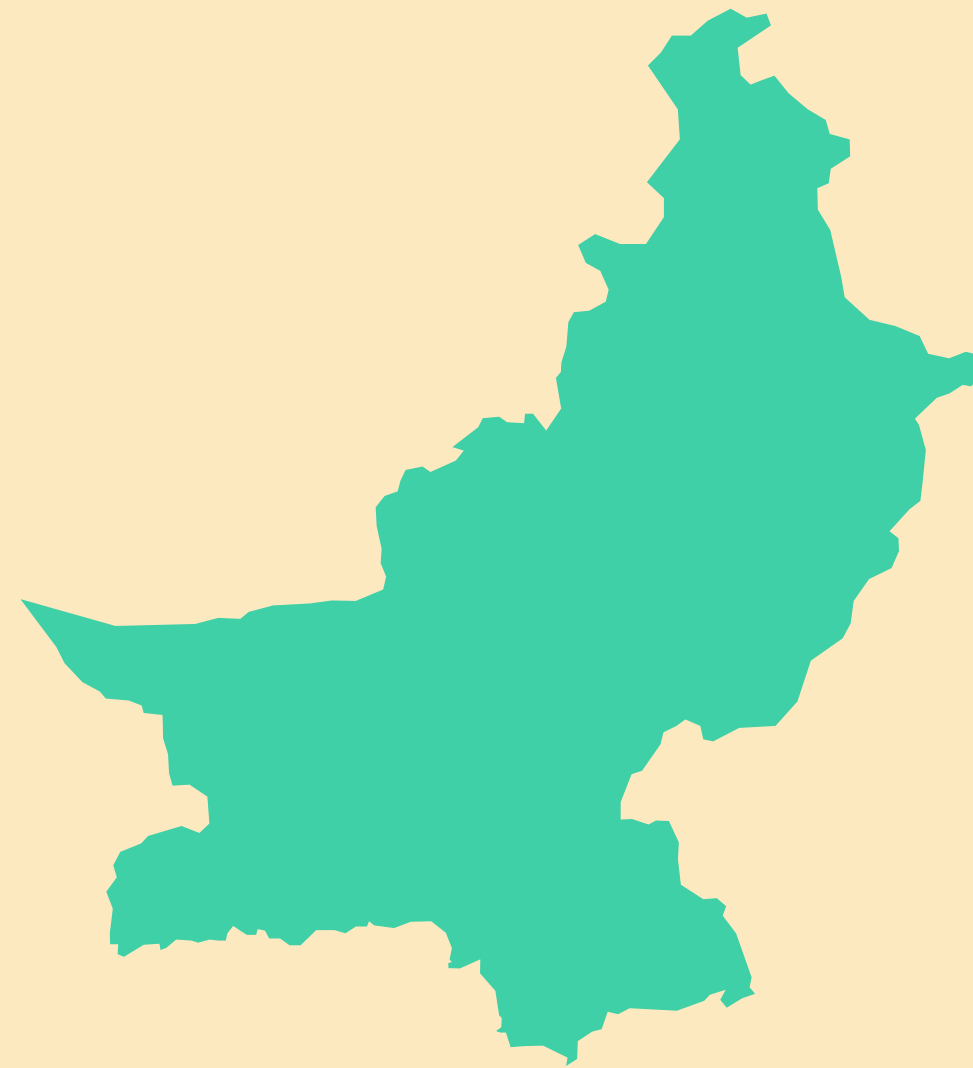
Drivers Of Behavior & Bias: Moment of Consultation



Overarching Insights



BURKINA FASO
BOBO-DIOULASSO &
OUAGADOUGOU



PAKISTAN
KARACHI



TANZANIA
DAR ES SALAAM

Insights

PROVIDERS

**“I WILL STILL NOT
BLAME THE PROVIDERS,
BECAUSE THEY ARE
PART OF THE SOCIETY
AND HAVE THEIR OWN
VALUES LEADING
TO BIASES.”**

—
Technical Expert, [Pakistan](#)

Insights ***Providers***



Providers see themselves as protectors of youth; their empathy can be a powerful driver of bias. But they also protect community norms which can limit youth agency and access to services. These norms are only partially influenced by training.

Insights ***Providers***

“WE JUST PROVIDE ENOUGH TRAINING TO THE PROVIDERS TO HAVE THEIR NAMEPLATES PUT UP, BUT WE HAVE NEVER REALLY TRIED REDUCING THEIR BIASES, FEARS, GUILT, SHAME OR CONSOLING THEIR DREAMS, WHICH CAN BE ACHIEVED BY FIRST OVERCOMING BOTH INTERNAL AS WELL AS EXTERNAL BARRIERS. THIS IS POSSIBLE WITH KNOWLEDGE, DEEP UNDERSTANDING, EMPATHY, ACKNOWLEDGEMENT AND CONFIDENCE.”

–

Technical Expert, [Pakistan](#)



Insights Providers

YOUTH ≠ CLIENTS:

Young people are not valued as clients by providers and other clinic staff, and clinics are unwelcoming places.

FERTILITY FIRST:

Providers fear that long-acting hormonal methods damage a young woman's fertility, with serious social and health consequences.

TIMING IS EVERYTHING:

There's an implicit timeline when it's appropriate to talk about sex and contraception. Marriage and, in some settings, childbirth, makes this conversation acceptable.

CLINIC VS COMMUNITY:

Providers have one foot in the community and one foot in the clinic and their values can conflict with their training. They fear community backlash for providing services, especially to unmarried youth.

PROVISION LEADS TO PROMISCUITY:

Providers shared community fears that giving contraception would encourage risky sexual behavior and promiscuity.

YOUTH ≠ CLIENTS

Young people are not valued as clients by providers and other clinic staff, and clinics are unwelcoming places.

They Don't Even Give You A Chair

'Carole' arrived at her local clinic at 8am. Without any signage she was lost and no-one gave her information about where to go. She stayed in the line for almost 2 hours. Once it was her turn, she was told she was in the wrong place, and sent elsewhere to wait again. Finally she entered the consultation room, where she was met by five providers.

"I'm here for family planning information" she said. "We only see those who want the methods. You must go back out and wait,"

the providers responded. She waited again until 12pm. Once it was her turn, they called her back. She was not given a chair, as she was only there for information. "I felt like they were watching a movie of me. There were five providers and all eyes were on me."

—

Mystery Client Experience, Burkina Faso.

Insights Providers



FERTILITY FIRST:

Providers fear that long-acting hormonal methods damage a young woman's fertility, with serious social and health consequences.

Insights Providers

“I feel guilty giving injections and OCPs to young women because once they choose become pregnant, they will not be able to conceive at the right time as it takes longer to return to fertility.”

–

Provider, Tanzania

“In our society, infertility is a nightmare.”

–

Provider, Tanzania

“For newly-wed clients younger than 20 years old, I advise them to conceive once then go for birth spacing...If we start them on a method at zero parity, chances are they will have difficulty conceiving when ready because these methods have side effects.”

–

Provider, Pakistan

“I will not readily offer an injection to a young girl because of the delay to return to fertility. I will only offer if the client insists.”

–

Provider, Burkina Faso



TIMING IS EVERYTHING:

There's an implicit timeline when it's appropriate to talk about sex and contraception.

Insights Providers

“The proper age of giving birth is 20-34 years, so providers should be careful in giving LARCs to these age groups.”

–

Nursing Assistant, Pendo, Tanzania

“We do not see newly wed couples or un-wed as our clients. We do not counsel families who have no children, or less than one or two.”

–

Community Mobilizer, Pakistan

“[The provider] mentioned the purpose of this center is to serve cases like [youth] but... she can only offer you services a week before your marriage.”

–

Young woman, Pakistan

“Having sex before marriage is okay, as long as the boy is going to marry you.”

–

Provider, Burkina Faso



CLINIC VS COMMUNITY:

Providers have one foot in the community and one foot in the clinic and their values can conflict with their training. They fear community backlash for providing services, especially to unmarried youth.

Insights Providers

“Parents don’t want them to start having sex and destroying their reproductive organs.”

–

Provider, Tanzania

“If we see a client as young as 16, we do convince her for contraception. Even if she does agree, there isn’t much a provider can do in cases where the husband is adamant that he will not allow contraception.”

–

CHW, Pakistan

“We are also sisters, mothers, friends. This is where we fail as providers.”

–

Provider, Burkina Faso



PROVISION LEADS TO PROMISCUITY:

Providers shared community fears that using contraception encourages risky sexual behavior and promiscuity.

Insights Providers

“I would feel sorry for the girl [if she uses LARC]. She’s going to go out and have sex. She could die.”

–

Provider, Private clinic, Tanzania

“What would you think if an unmarried girl came for family planning?” “I would think she is a prostitute.”

–

Female Provider, Private clinic, Tanzania

“How should I believe that you have had your Nikkah [marriage]? What if you are lying? I know girls like you very well - I am sure you guys meet and talk to each other frequently... I know what your character is like, I have been in this position for the past 40 years, so I can tell very easily.”

–

Female Provider, Pakistan

“Many providers see their daughter, and giving a method will be exposing her to unsafe sex and risk.”

–

Female Provider, Burkina Faso



Many providers were motivated by empathy and a drive to serve their communities.

“SINCE CHILDHOOD, I HAVE ALWAYS WANTED TO BECOME A DOCTOR AND A PROVIDER OF QUALITY HEALTH CARE TO THE PEOPLE – TO WORK WITH ALL MY HONESTY, NOT TO MISUSE THIS PROFESSION AND NOT TO MAKE IT A MEANS OF JUST MAKING MONEY BY EMPTYING POCKETS OF THE PATIENTS, BUT INSTEAD PROVIDE THEM HEALTH CARE AND, BY GRACE OF GOD, THAT’S WHAT I HAVE BEEN DOING.”

—

Provider, Pakistan

Insights *Providers*

Positive Practice



Insights ***Providers***

Positive Practice

PROVIDER TAKE REAL RISKS TO DELIVER CARE TO WOMEN IN NEED, SOMETIME PROVIDING SERVICES IN SECRET

“I have been to very conservative Pathan communities...we have to be very careful when dealing with such clients, as it can be a threat to our lives.”

–

CHW, [Pakistan](#)

“We have become very confident over time, developed tolerance and patience... so we are able to work in such a challenging environment.”

–

CHW, [Pakistan](#)

“Some youth can access family planning methods through some providers who provide at their homes.”

–

Provider, [Tanzania](#)

PROVIDERS MAY TAKE ON A MATERNAL PROTECTIVE ROLE AND CREATE A POSITIVE EXPERIENCE FOR YOUTH

“It’s nice that you came here. Everything you say will be between us. You can consider me as your mother and if we meet outside here, we don’t have to say how we know each other.”

–

Provider to mystery client, [Burkina Faso](#)

PROVIDERS WILL WAIVE OR REDUCE COSTS FOR YOUTH

“In cases where a client has financial constraints, the provider will negotiate and agree to provide contraception at a much more affordable cost.”

–

CHW, [Pakistan](#)

MANY PROVIDERS WERE PRAGMATIC ABOUT THE NEEDS OF YOUNG PEOPLE, DESPITE COMMUNITY OPPOSITION

“When they’re coming, here, they already have a sex life.”

–

Provider, [Burkina Faso](#)

In all countries, misinformation and myths about contraception methods were widespread from both youth and providers. Here's some of the most common fears and stories we heard. The major fears about long-acting hormonal methods were infertility and disruption to the menstrual cycle.

Insights **Providers**

Methods & Myths

IUCD

- Concerns about adolescent anatomy (small vagina) making insertion difficult or impossible
- Belief the IUCD can travel to the heart or brain
- Fears about breaking hymen (even in sexually active girls)
- Worries that adolescents won't tolerate the pain
- Fear it will fail and be embedded in baby's head
- "The condoms get stuck with the IUD during sex." – *Sex worker, Pakistan*

EMERGENCY CONTRACEPTION

- Few fears and myths
- Most readily accessible from pharmacists
- "It does the job." – *Provider, Pakistan*

INJECTION

- Main fear is delayed fertility or infertility
- Most demanded method by youth
- Use of one month injection was preferred by many providers in Pakistan as safest hormonal method for young women
- Concern about disruption to menstrual cycle
- "If they don't bleed regularly, where is the blood going?" – *Provider, Tanzania*

ORAL CONTRACEPTIVE PILL

- Few fears and myths in general
- Seen as helpful to regulate menstrual cycle.
- Seen as something for married women in some contexts

IMPLANT

- Main fear is delayed fertility or infertility
- Seen as a waste of resources for youth, who may bear children soon
- Fear of movement and 'disappearing in the body'
- Belief that a fully sterile environment is needed for insertion
- "Too interventional and will scare clients away."
- "If she's 60kg or overweight, it won't be as effective." – *Provider, Pakistan*
- "The implant might travel in the blood and go to the heart." – *Youth, Tanzania*
- Was not provided in Green Star clinics (Pakistan)

Insights

YOUTH

**“YOUTH ARE THE
COMMUNITY’S IMAGE
AND THE SUCCESSION,
THEREFORE YOUTH
ARE THE COMMUNITY’S
TREASURE.”**

—
Provider, Burkina Faso

**Insights
*Youth***



The expectation that youth have the knowledge, confidence, and autonomy to be able to digest information and make an informed choice may be unrealistic.

Youth knowledge of contraception was often low and inaccurate, partly because sex is a taboo topic and also because they lack safe and knowledgeable resources for one-to-one or peer discussion. Visiting a clinic for contraceptive methods might be one of the first times they have visited alone and they are ill-prepared for how to behave in this setting. Young adolescents typically seek healthcare with parents, and are used to them making decisions for them. Gender norms further compound the difficulty for young women to exercise choice, as men and other family members (such as mothers-in-law in Pakistan) are priority decision makers.

“IN TIMES WHEN INTERNET AND TV HAVE BECOME ROUTINE, ONE SHOULD BE PREPARED FOR ANYTHING. SUCH PRECAUTIONS AND KNOWLEDGE WEREN'T NEEDED BACK THEN, AS PEOPLE LIVED IN A DIFFERENT TIME. NOW AS THE PROBLEMS ARE INCREASING, SO ARE THE SOLUTIONS - WE SHOULD EMBRACE WHATEVER FACILITIES [CONTRACEPTION] ARE BEING OFFERED. HOW MISERABLE ONE'S LIFE CAN BE IF YOU ARE A FATHER OF SIX, BUT WITH NO MONEY IN YOUR POCKETS. MY FRIENDS AND I SAW A MAN TRYING TO COMMIT SUICIDE ON THE RAILWAY TRACK...HE WAS JOBLESS, HAD ENDLESS DEBTS AND STARVING KIDS AT HOME. ”

—
Young man, [Pakistan](#)

NOT READY TO CHOOSE:

Youth lack the agency and the knowledge to know what they need, seek it and exercise reproductive choice. Youth are unprepared to access services and are inexperienced consumers.

YOUTH EXPECT LITTLE:

It’s hard for young people to know what quality of service means - and they have no voice to hold providers accountable for poor care.

CONFIDENTIALITY IS KEY:

Youth also prioritized empathy, privacy and good communication. However, they fear that the provider will not protect their confidentiality when they seek contraception or they will be seen.

YOUTH, TECHNOLOGY & INFORMATION:

Youth are well connected and even illicit information can travel rapidly, leveraging social networks and social media.

NOT READY TO CHOOSE:

Youth lack the agency and the knowledge to know what they need, seek it and exercise reproductive choice.

Insights Youth

“I would not trust peers to pass correct information to fellow adolescent as they are young; easily misdirected and pass wrong information.”

–

Provider, Tanzania

“The provider can only intervene [with contraception] once the husband allows. Even if the female still persists on contraception, she may be threatened to leave the house. So that doesn’t leave her with much of a choice there.”

–

Provider, Pakistan

“The majority of these [young] women live in a joint family set up where they have to please everyone in order to survive”

–

Provider, Pakistan

“We have no power to make a decision and we don’t have the right to make a decision in our community.”

–

Female Youth, Burkina Faso



YOUTH EXPECT LITTLE:

It's hard for young people to know what quality of service means — and they have no voice to hold providers accountable for poor care.

Insights Youth

Mystery clients in Tanzania rated providers moderately youth-friendly who did 'nothing right' or who were heavily biased toward one method.

—

Youth, Tanzania

“Youth lack confidence and ability to first understand their sexual health needs, and then how to communicate them, and finally, to demand services they need from the provider.”

—

Provider and Head of Health Services Green Star), Pakistan

“Young woman are not listened to in our society and their point of view is not taken into account.”

—

Young woman, Burkina Faso

“She was very polite. She even offered us water.”

—

Mystery client, Pakistan, on provider who told them to have a baby rather than use contraception and offered only one method: a one month injection



CONFIDENTIALITY IS KEY:

Youth also prioritized empathy, privacy and good communication. However, they fear that the provider will not protect their confidentiality when they seek contraception or they will be seen.

Insights Youth

“Young people go to the clinic at night, so no-one sees them.”

–

Provider, Burkina Faso

What do you want to hear from a provider when you visit a clinic?

“If you come here, there’s nothing so huge that you can’t get help.”

–

Youth, Tanzania

“I see pregnant girls that have gone through Nikkah [legal marriage] but are just waiting for their Rukhsati [consummation]. They worry about their family finding about the pregnancy; we advise them to get done with Rukhsati because I personally don’t recommend abortion. We try to help them in talking to their mothers or anyone in the family they are close to.”

–

Provider, Pakistan



YOUTH, TECHNOLOGY & INFORMATION:

Youth are well-connected and even illicit information can travel rapidly, leveraging social networks and social media. Boys have easier access to information due to freedom, schooling and less stigma.

Insights Youth

“Smartphones play a big part in spreading family planning information.”

–

Young man, Pakistan

“We can get information anywhere we want it. You just look for a topic and it’s there on your phone.”

–

Sex worker, Pakistan

“I am the FP and sex expert. My friends come to me for information.”

–

Young man, Burkina Faso



Photo credit: Shahbano Khushi

CHOICE VS RECOMMENDATION:

Young clients expect providers to choose contraception for them, but according to quality standards, providers are being trained to offer a range of methods. Providers gain satisfaction when a client accepts their recommendations.

Insights Youth

“Clients who are compliant, who religiously follow our advice and follow up regularly... these are the kinds of patients we hope to see daily.”

–

Provider, Pakistan

“On the good days, clients are standing up and following me from health education to the family planning room.”

–

Provider, Tanzania

“You’re the provider, what’s your suggestion?”

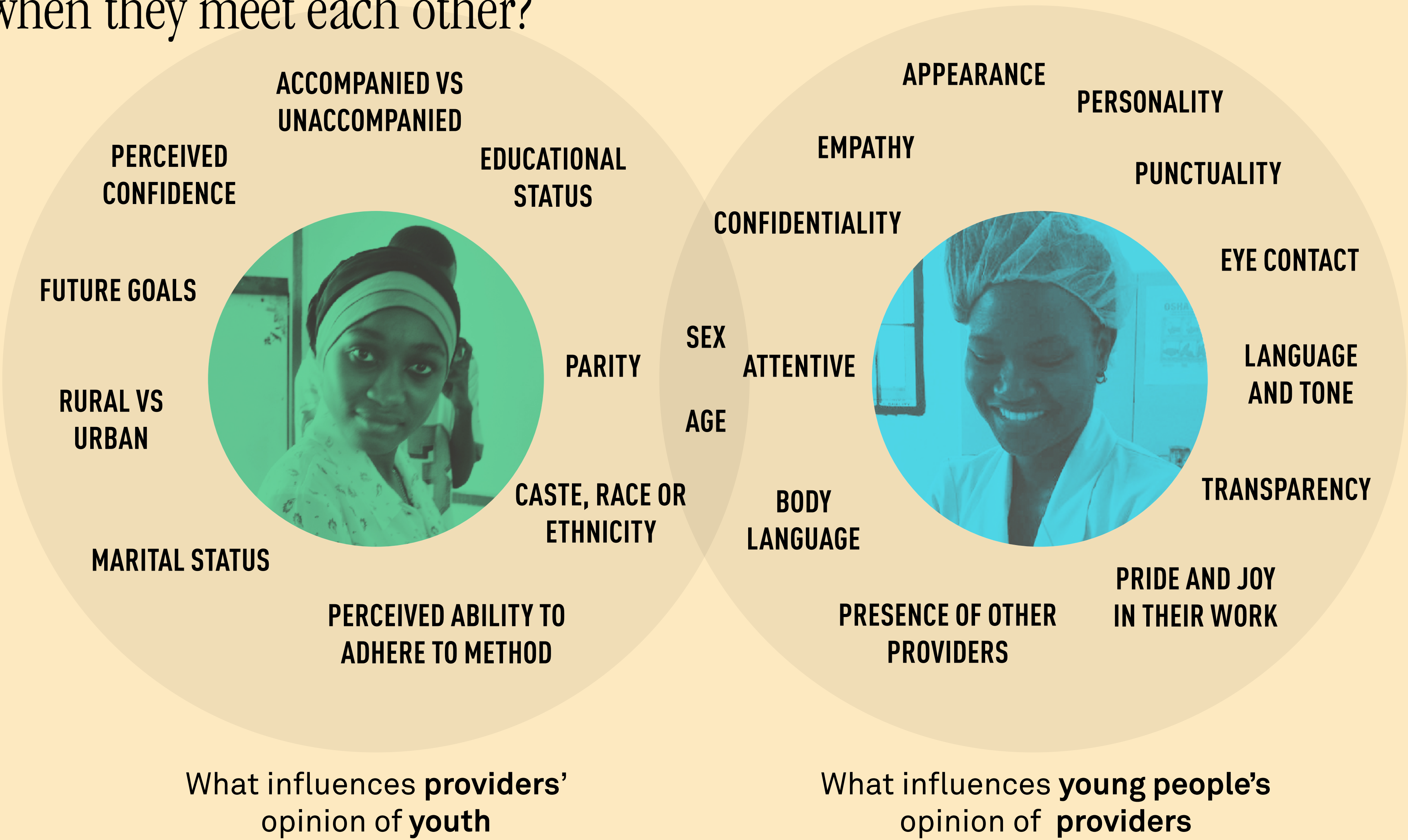
–

Young woman in role play with ‘provider’, Burkina Faso



PROFILING PREJUDICE

What influences youth or provider behavior when they meet each other?



Insights

COMMUNITY

Young women are under great pressure from their families and community to fulfill their expected reproductive duties.

Not only were young women expected to protect the image of the community through obedient behavior, but community leaders across all countries believed that it is a young woman's duty to get married and have as many children as possible.

Youth lack detailed information about their rights and sexuality due to community taboos and have no voice to advocate for themselves. Falling pregnant brings great shame and humiliation for young women, and also for their families.

STIGMA & SECRETS:

Though communities recognize that teen pregnancy is a problem, stigma, taboo and shame block conversations about contraception. There's a fear that sex education will promote promiscuity among youth.

SHAMED FOR PREGNANCY, SHAMED FOR PREVENTING PREGNANCY:

Being discovered as a contraceptive user or falling pregnant prior to marriage puts young women at serious risk of physical violence, abandonment and public shaming.

REPRODUCTIVE DUTY:

A woman's reproductive duty is highly valued - children bring social capital, prestige, and acceptance. Infertility can be catastrophic.

REPRODUCTIVE DUTY:

A woman's reproductive duty is highly valued — children bring social capital, prestige, and acceptance. Infertility can be catastrophic.

Insights ***Community***

“In Tanzania, a newly married woman is expected to have her first child as soon as she enters wedlock. If that does not happen she will be terribly embarrassed.”

—

Young woman, Tanzania

“You don't want a kid? It's a blessing from God...It is better that you have one baby at least and then you can think about a gap of 3 to 5 years then.”

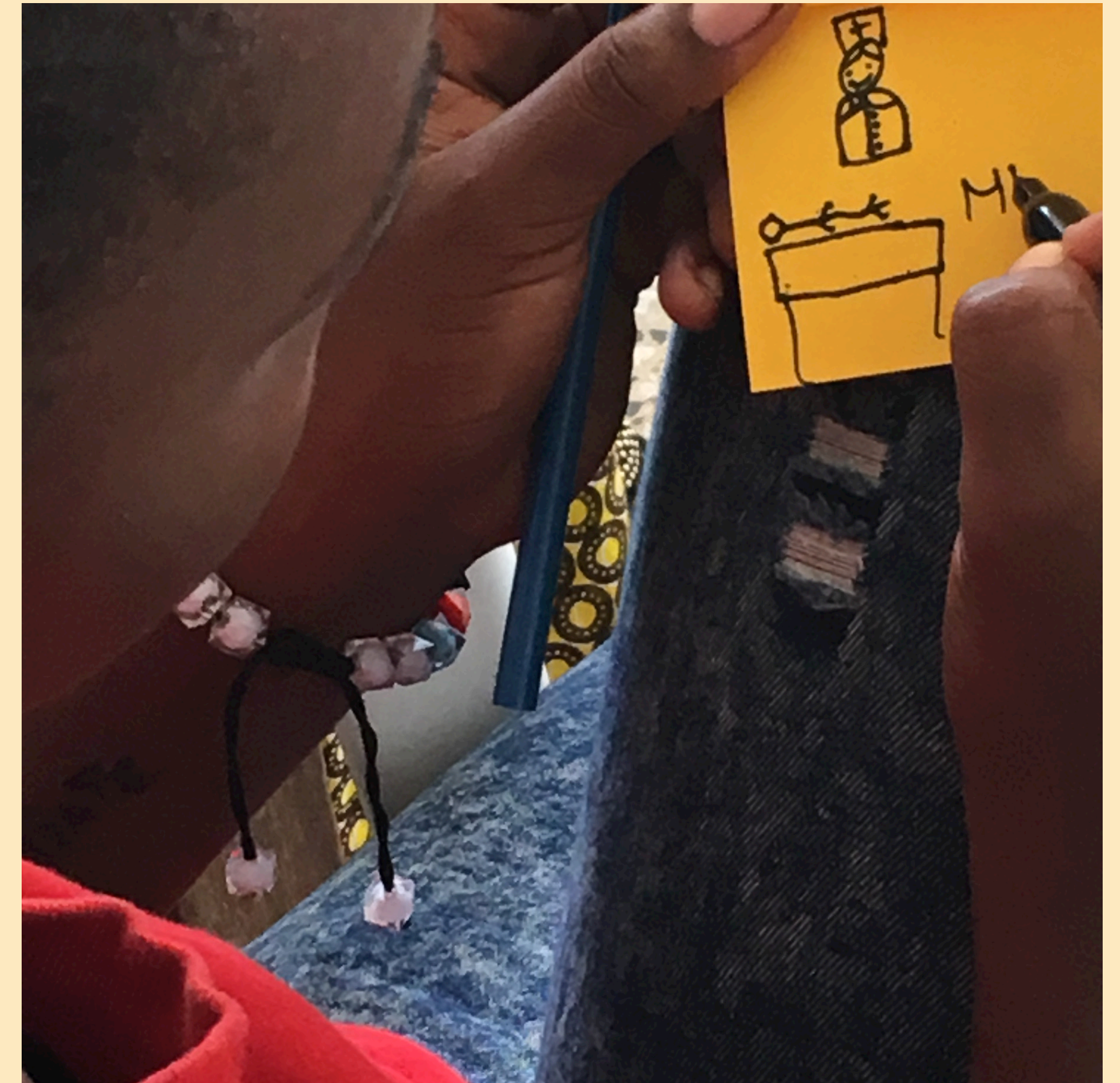
—

Provider, Pakistan to
Mystery Client couple

“Young women are obliged to have children.”

—

Young woman, Burkina Faso



SHAMED FOR PREGNANCY,
SHAMED FOR PREVENTING
PREGNANCY:

Being discovered as
a contraceptive user
or falling pregnant
prior to marriage
puts young women
at serious risk of
physical violence,
abandonment and
public shaming.

Public shaming for pregnancy out of wedlock

*“Society’s children are everyone’s children, so
[the community] has the right to correct them.”*

– Youth woman, Burkina Faso

A provider shared this story: In Bobo-Dioulasso a young girl living in a Christian community became pregnant before marriage. Her mother found out. Fearing the dishonor of having a young unmarried daughter fall pregnant, she took her for a clandestine abortion. Post abortion the young girl was screaming in pain. The mother then took her daughter to the medical centre for an examination where she was treated for complications. She asked that her daughter be treated in the far away dispensary so that no-one would find out, yet the community came to know. The mother and daughter were publicly shamed by the local Protestant pastor before the church congregation, stigmatizing the young girl and mother.

Insights Community



STIGMA & SECRETS:

Though communities recognize that teen pregnancy is a problem, stigma, taboo and shame block conversations about contraception. There's a fear that sex education will promote promiscuity among youth.

Insights Community

“Parents are ‘difficult’ to allow their children to use family planning methods, because they fear that they will become promiscuous.”

–

Provider, Private clinic, Tanzania

“Unmarried girls seeking contraception need to be reminded that it's wrong. I hear their side of the story in detail and advise them to refrain from such activities.”

–

Provider, Pakistan

“I go on the internet to seek information because there, no-one knows me and no-one sees me.”

–

Young woman, Burkina Faso



Insights

STRUCTURAL

Though there is growing policy and legal support for providing contraception to youth, significant health system barriers disproportionately affect young people.

In all three countries, in both private and public clinics there was a lack of attention to quality, and targets were based on the number of clients seen, rather than their experience. In particular, providers are not incentivized to improve services for youth and had little accountability for low quality care.

Insights **Structural**



Insights

Structural

PROVIDER PRESSURE:

Providers are over-worked and under-resourced, which makes it hard to prioritize youth seeking non urgent services.

TRANSPARENCY OF COSTS:

Cost of services is not transparent, often inflated by providers, and is mostly unaffordable for young people.

LITTLE OR NO ACCOUNTABILITY:

Though providers are encouraged to hit targets for clients, there's little accountability and reward for providing quality services to youth.

CONFUSION ABOUT POLICY:

There's widespread confusion about the national policy and clinical standards for serving youth, even where national guidelines support young people's access to services.

CLINIC EXPERIENCES

Insights Structural

“Our clinic is very tiny. It’s the same place we offer ante-natal care, PMTCT and family planning. A youth can’t feel comfortable to visit such a place due to privacy issues.”

–

Provider, Government clinic, Tanzania

“The agreement that is signed by the providers is hardly of any legal significance or value, it’s just a piece of paper...Only 20-30 % of the time is it possible to do client observation. I have not seen [client exit interviews] taking place.”

–

Green Star Senior Administrator, Pakistan

“If you don’t have money, you won’t be welcomed nicely in a health facility. The providers will shout at you.”

–

Young woman, Burkina Faso

“The cost of service provided is dependent on the place. If youth have to pay and it’s the only place for them to receive methods they may stop using contraception.”

–

Female Provider, Burkina Faso

Insights



TANZANIA



**“GIVING BIRTH IS PRIDE.
YOU MAY NOT HAVE WEALTH
BUT YOU HAVE KIDS.”**

—
Technical Expert, Tanzania

Encouraging youth to use family planning is seen as limiting fertility. Childbirth means a validation of womanhood, social success and a contribution to Tanzania's future.

IN TANZANIA, most of the providers interviewed worked in the public sector and had received YFS training. Knowledge did not always correlate with good practice, as providers' own values and norms often competed with their training. Fears about the impact on fertility of LARCs and on HIV risk, and lack of experience in providing LARC, meant condoms and abstinence were the most commonly recommended methods for youth. There is a low demand from youth for contraception in clinics, particularly for LARC, about which youth knew little. We heard that contraception is seen by communities as a Western agenda to control the population, leading to mistrust and opposition.

Insights ***Tanzania***

TOO MUCH OR TOO LITTLE:

Too much or too little information was troublesome for teens and some expected the provider to choose a method for them.

LESS THEY KNOW THE BETTER:

Fear of catalyzing transition to adulthood. Providers don't want to bear the responsibility and risk of giving 'adult' information to youth before they are ready.

BAD NEWS TRAVELS FAST:

Youth rapidly share scare stories of harmful effects of contraceptives. These 'myths' are grounded in real fears about methods.

**“I FELT GOOD AS
THE PROVIDER WAS
SO MOTHERLY AND
RECOMMENDED A
METHOD THAT WAS
APPROPRIATE FOR ME.”**

—
Mystery client, Tanzania

Insights ***Tanzania***

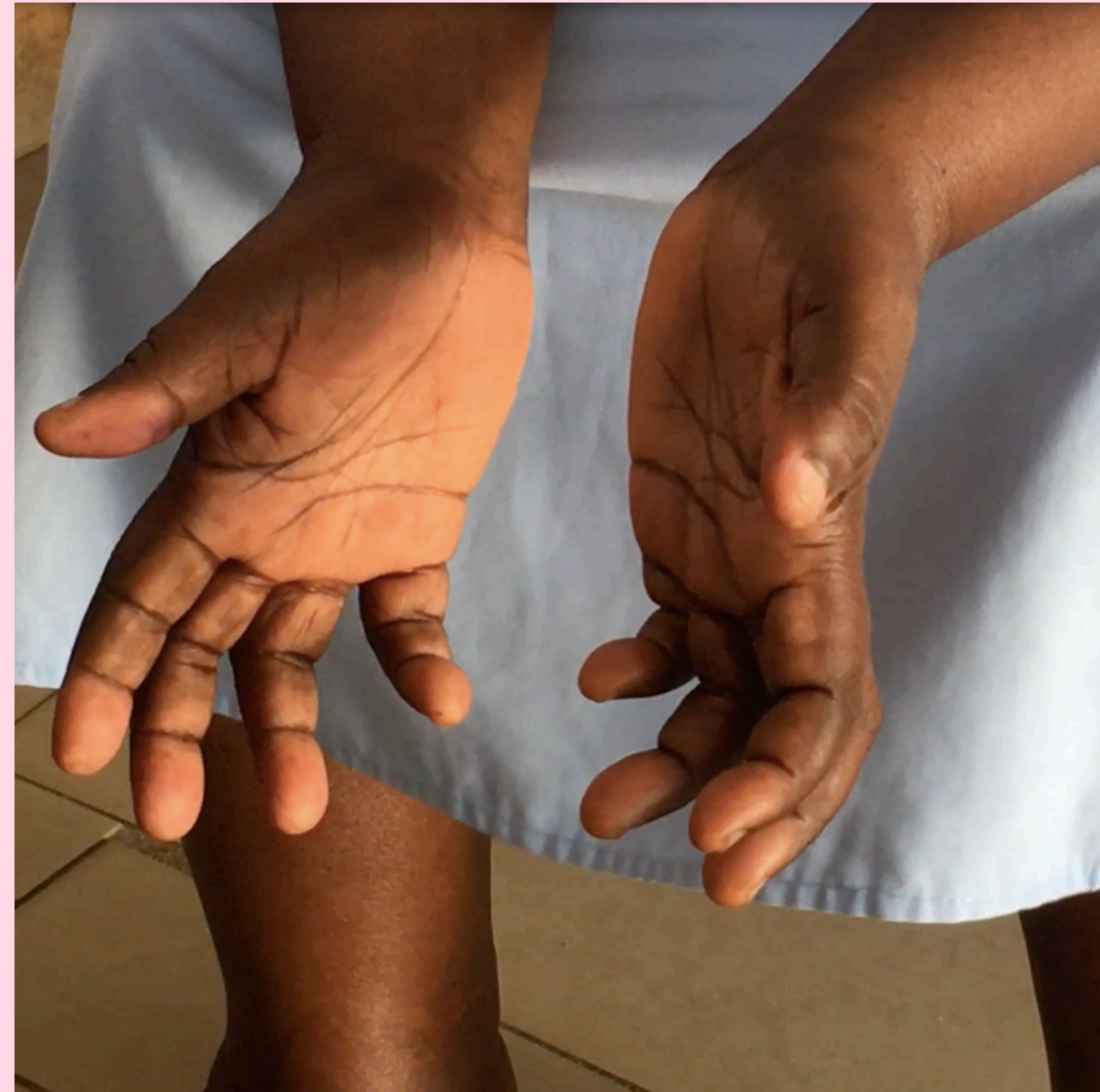


**TOO MUCH OR
TOO LITTLE:**
Too much
or too little
information was
troublesome
for teens and
some expected
the provider
to choose a
method for
them.

“THEY HAVEN’T STARTED SEX YET SO WHY GIVE THEM THE IDEA OF IT?”

—
Female youth-focused nurse,
on giving information to pre-menarchal girls, [Tanzania](#)

Insights ***Tanzania***



**LESS THEY
KNOW THE
BETTER:**
Providers feared
catalyzing the
transition to
adulthood with
information.
Providers don’t
want to bear the
responsibility
and risk of
giving ‘adult’
information to
youth before
they are ready.

“I WOULD NOT TRUST PEERS TO PASS CORRECT INFORMATION TO FELLOW ADOLESCENTS, AS THEY ARE YOUNG, EASILY MISDIRECTED AND PASS WRONG INFORMATION.”

—
Provider, Kibugomo, Tanzania

Insights ***Tanzania***



BAD NEWS TRAVELS FAST: Youth rapidly share scare stories of harmful effects of contraceptives. These ‘myths’ are grounded in real fears about methods.

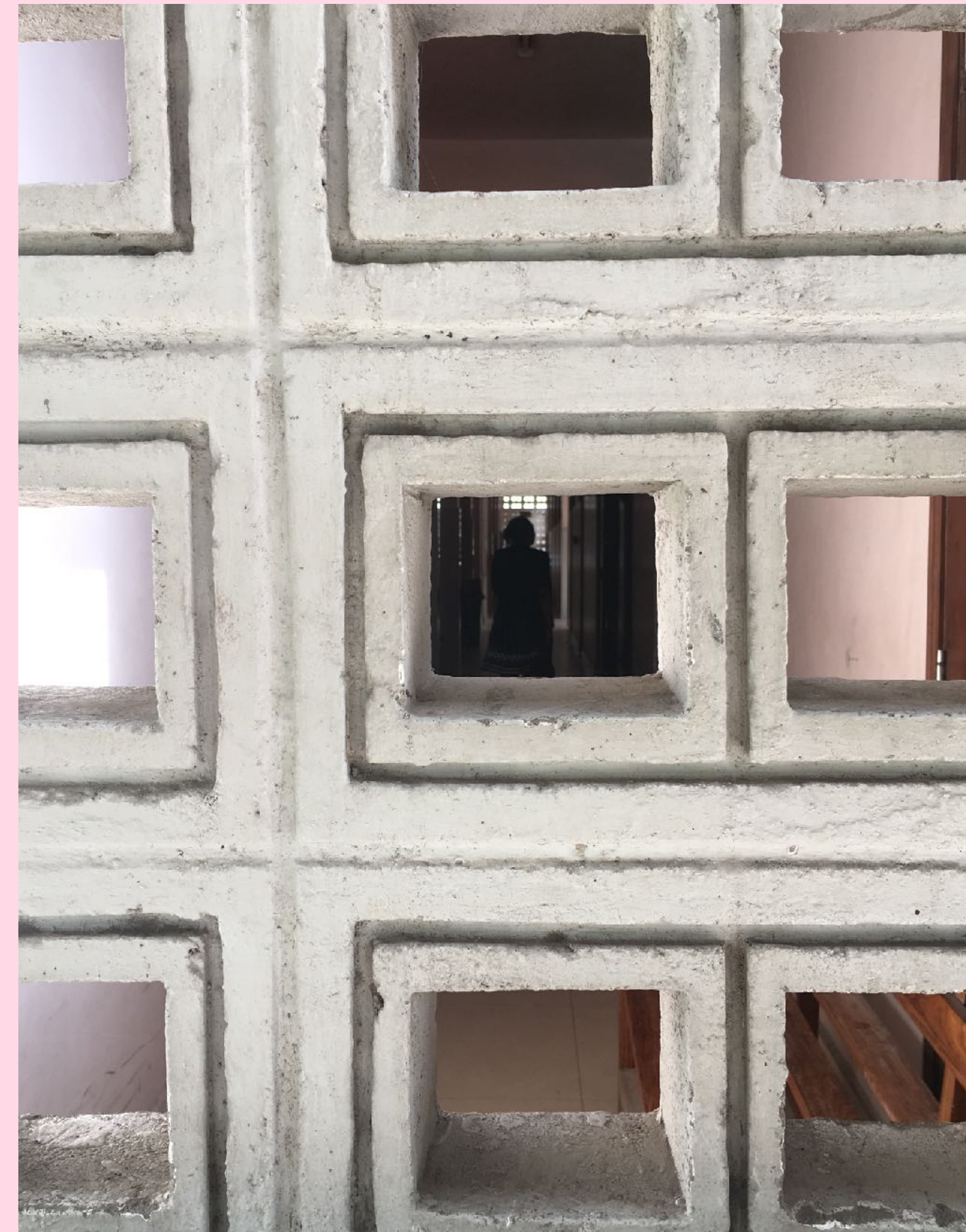
Playing Protector, Playing Parent

Insights Providers

“I’d be ashamed and angry that she hid all of this from me. That she went to a different provider than me.”

-
Provider, Tanzania

After journey mapping her experience of providing SRH services to a young unmarried girl, we asked the provider how she’d react if her own daughter sought out contraception in secret. She was speechless. Thinking not only as a provider, but also as a mother, she felt this would reflect her failure as a parent and her greatest fear for her child was community backlash. As a provider, her disagreement with youth having sex before marriage stemmed from concern for their well-being, rather than from condescending judgement.





Insights

PAKISTAN

Photo credit: Wasif Malik

“FOR US, UNMARRIED GIRLS ARE NOT CLIENTS.”

— Community health worker, [Pakistan](#)

Access is mostly limited to married women with children and permission. Young people lack legitimate sources of information on contraception.

IN PAKISTAN, almost all providers interviewed worked in Green Star private social franchises. Most had no training in youth-friendly services and, in general, AYSRH services are not prioritized in Pakistan. These providers were more financially motivated, and providers often took advantage of their power to inflate prices. Unmarried girls are not considered legitimate clients, and even married nulliparous youth struggle to access contraception. Women are often asked for a marriage certificate to access services and expected to be accompanied. In the Green Star network, one single provider does not offer a full range of methods, as services are fragmented across multiple provider types.

Insights
Pakistan

LOW PROFIT, HIGH RISK:

Clinics are a business. Counseling youth clients yields lower profits and higher risks.

FAMILY RULES:

Providers and couples defer to the mother-in-law for contraceptive decisions. The mother-in-law's attitudes and behaviors regarding family planning can be the strongest influence on a young couple's intentions to use contraception.

CHWS ARE EXPERT NAVIGATORS:

Community health workers know how to navigate community opposition to support access to contraception, but youth and newly weds are not their target clientele.

WEARING TWO HATS:

There is little division between the personal and professional world of a provider, especially female providers running clinics out of their home.

“A CLIENT PAYS YOU ONLY 100 BUCKS FOR AN INJECTION, WHY WOULD YOU SPEND ANOTHER 15 MINUTES ON COUNSELING WHEN IN THAT TIME YOU CAN SEE MORE PATIENTS HENCE MAKE MORE MONEY.”

—
Provider, [Pakistan](#)

As private providers, operating as Green Star social franchises, profitability is an important concern. Previous non-monetary incentives from Green Star have ceased. In contrast to pregnancy-related services, family planning is less profitable. We heard that providers often inflate the cost of

products and services for their clients on a case by case basis e.g. increasing the cost of contraception for sex workers or young clients. Providers were opportunistic: for example, one offered 1 month injections over 3 months so the client will return to purchase further products and services.

Insights ***Pakistan***



**LOW PROFIT,
HIGH RISK:**
Clinics are
a business.
Counseling
youth clients
yields lower
profits and
higher risks.

“FIRST SHE’LL DISCUSS IT WITH HER HUSBAND, THEN HER MOTHER-IN-LAW. ONCE SHE APPROVES, THEN SHE’LL HAVE TO ARRANGE THE MONEY FOR IT. SHE’LL COME TO US AND WE TAKE HER TO THE DOCTOR WHO THEN OFFERS HER THE TYPE OF METHOD MOST SUITABLE FOR HER.”

CHW on how a young married woman would decide on a method, [Pakistan](#)

A married couple, regardless of educational level, usually defer to the husband’s mother, which can restrict the woman's reproductive choice. We heard that the mother-in-law’s attitudes and behaviors regarding family planning can be the strongest influence on a young couple’s intentions to use contraception, and the attitude a young girl develops regarding the use of contraception in

the future. Providers told us that it was rare for a mother-in-laws to support contraceptive use for young married women, even those with children. Childbearing is seen by the community as an action to sustain both the family and community, and a preference for sons influenced decision making by providers and families.

Insights *Pakistan*



Photo credit: Wasif Malik

FAMILY RULES:
Providers and couples defer to the mother-in-law for contraceptive decisions.

“I ONCE MANAGED TO CONVINCE A PATHAN LADY TO TALK ABOUT CONTRACEPTION, SHE USHERED ME INTO HER HOUSE. A MOMENT LATER THE MALES ARRIVED AND, SEEING ME THERE WITH MY PAMPHLETS, STARTED SCREAMING AT THEIR LADIES FOR LETTING ME IN. I SAT QUIETLY THERE, UNTIL ONE OF THE MEN ASKED ME TO LEAVE.”

—
CHW, [Karachi](#)

CHWs are savvy about navigating the sensitivities around providing contraceptive services in their communities and are experienced at cultivating good working relationships with community leaders and providers. They are respected by youth

and demonstrated strong empathy and connection with young women. However, CHWs do not currently reach or attempt to reach young clients, regardless of marital status.



CHWS ARE EXPERT NAVIGATORS: Community health workers know how navigate community opposition to support access to contraception, but youth and newly weds are not their target clientele.

“BEFORE WE GET READY FOR WORK, WE HAVE TO MAKE SURE THAT ALL THE HOUSEHOLD CHORES AND DOMESTIC WORK HAVE BEEN TAKEN CARE OF IN ORDER FOR US TO BE IN A MORE RELAXED STATE OF MIND WHEN WE LEAVE FOR WORK.”

Female provider, [Pakistan](#)

Providers constantly switch between many roles when offering clinical services, including parent, spouse, mother-in-law and community member. They are running both their home and their clinic which have conflicting and competing priorities.

Throughout their working day, they have to meet all of the gendered expectations related to domestic duties while simultaneously running their clinics.

Insights ***Pakistan***



WEARING TWO HATS:
There is little division between the personal and professional worlds of a provider, especially female providers running clinics out of their home.

YOUTH VOICES

Insights Pakistan

“When a boy reaches puberty, he can discuss [sex] with his friends and they have easy access to all these things, since they stay out of their homes most of the time. But girls are usually homebound, not every girl goes to school... It is these elders who are responsible for providing the young girls with information on menstrual cycles etc. As long as a girl is getting this information from home, it is good. The moment her source becomes an outsider, the chances of her becoming involved in ill-doings increase”

- Young man, Pakistan

“Nowadays I think it is the internet and the Bollywood movies. They are spoiling the girls...the devil whispers in her ear and she will develop this urge to ask about that scene from someone else, and here is where all the trouble starts.”

- Young man, Pakistan

"My own friend, she went for D&C to a provider. He offered her his services only under one condition that she agreed to have sex with him, can you believe it? Well, she refused and obviously she stayed pregnant for 5 months until she underwent the procedure. It was so complicated she had part of her uterus removed too.”

- Young woman, Pakistan

"If we ask for a condom, they counsel us to get an IUD instead. Condoms give protection against HIV - ring (IUD) won't give that protection. Fine, go ahead, make your services better, but the importance of condoms in HIV prevention is great.”

- Sex worker, Pakistan

YOUTH EXPERIENCE

Our mystery clients were briefed thoroughly before accessing clinics to ask for information on their contraceptive options. This is the experience of two young people playing a married couple with one child hoping to space births.

The Last Five Steps

“We were very nervous with so many questions arising in our mind. We thought to ourselves that it would be even tougher inside. For several minutes we kept pacing to and fro before the clinic door, debating with ourselves if we should go inside. Eventually we mustered up the courage and walked into the door which led us to the receptionist. She gave us a judgmental stare and then scrutinized us from head to toe which made us even more nervous.”

We were called in after a couple of minutes and [the provider] asked Hina about her demographics. Then she asked us about the problem. Hina gave her a little history of our marital status and then said that we are here for contraception.

Hina: "Yeah, so she asked me about how many kids I had. I told her that I have a kid who's a year old. 'So you're here for contraception?' and without any further word or counselling, she asked the receptionist to fetch some pamphlet with pictures of all the contraceptive methods and the services available at her clinic. The receptionist couldn't find it. So I just added, 'I want to get a capsule', [OCP] to which she replied that we don't have capsules, we just offer injections...for one month."

Insights Pakistan



Insights

BURKINA FASO

**“YOUTH ARE THE TREASURE
OF THE COMMUNITY.
THEY ARE THE RICHNESS.”**

—
Female youth, Burkina Faso

Providers are over-stretched
and youth clients are low priority.
Lack of time and space means
services are not confidential.
Youth have very few avenues
to learn more.

IN BURKINA FASO, we mainly interviewed providers working in the public sector with variable training in youth-friendly services. Prominent themes in Burkina Faso were disrespect and lack of confidentiality for youth seeking contraception. Clinics were not a safe space for youth. Schools were seen as an opportunity to create safe spaces where providers can reach youth with age appropriate information, supported by national policy. The community recognizes teen pregnancy as a problem and, in some settings, were working to support youth, though others were strongly opposed to giving information to youth.

Insights
Burkina
Faso

NO RESPECT, NO VOICE:

Young clients are not given respect and confidentiality in the clinic. Providers do not prioritize young clients and youth have no voice to advocate for better services.

BURN OUT:

Providers are burned out and busy, making it hard to prioritize young clients.

COST BARRIER:

Youth can't afford sexual and reproductive health services and methods, and costs are hard to guess.

Insights
Burkina
Faso

PARENTS BEAR THE SHAME:

Though parents bear the shame of an unplanned pregnancy, parents and youth aren't comfortable talking about sex, puberty and contraception.

SCHOOLS ARE ACCEPTABLE CONDUITS

OF INFORMATION: Sexual and reproductive information shared from the school may be more acceptable to parents and caregivers. Currently school ed is lacking.

REPRODUCTIVE ROLE:

A young girl is under great pressure to fulfill the community's expectations of her reproductive role as a woman.

**“I’M HUNGRY.
IF YOU ARE ONLY HERE
FOR INFORMATION
THEN COME BACK
TOMORROW.”**

—
Provider to mystery client, Bobo-Dioulasso

We heard that providers do not respect the rights and needs of young people seeking information about contraception. Information youth are given was too general, didn’t meet their expectations, and is not kept confidential. Lack of space and

client volume meant our mystery clients were seen in the same room as five other providers and clients or in corridors. Long waiting times, unwelcoming environments and lack of signposting contributed to a poor experience for youth.

Insights ***Burkina*** ***Faso***



**NO RESPECT,
NO VOICE:**
Young clients are not given respect and confidentiality in the clinic. Providers do not prioritize young clients and youth have no voice to advocate for better services.

“IF THE QUESTION IS, ‘ARE YOU OVERWHELMED?’ THE ANSWER IS YES...[BY] TOO MANY CLIENTS AND NOT ENOUGH STAFF, LONG WORKING HOURS, AND LITTLE SUPPORT AND RESOURCES FROM THE MINISTRY.”

—
Provider, Bobo-Dioulasso

Providers are tired and over-worked, reducing their energy to stay motivated and empathetic to serve youth. Their challenging work environment with competing priorities such as obstetric emergencies,

stockouts, and lack of senior support, space and resources makes their job not enjoyable.

Insights ***Burkina*** ***Faso***



BURN OUT:
Providers are burned out and busy, making it hard to prioritize young clients.

**“CAN YOU IMAGINE
A CONSULTATION IS
1000 CFA...HOW
ARE YOUTH SUPPOSED
TO AFFORD THAT?”**

—
Young woman, Ouagadougou

We heard from youth that one of their biggest challenges is finding employment. This is particularly challenging for young people when it comes to accessing AYSRH services because they don't feel comfortable

asking their parents for money and little other sources of income. Additionally, there is no standardized pricing for consultation services and methods making the cost difficult for youth to estimate.

Insights ***Burkina*** ***Faso***



COST BARRIER:
Youth
can't afford
sexual and
reproductive
health services
and methods,
and costs are
hard to guess.

**“MY PARENTS TALK
TO ME ABOUT
PUBERTY AND BODY
CHANGES WHILE
INSISTING ON
ABSTINENCE UNTIL
MARRIAGE.”**

—
Young man, Ouagadougou

We heard from the community and youth that it's the obligation of parents to talk to their children about puberty and sex. Parents are not talking to their teenage sons and daughters about contraception, yet expect them to prevent pregnancy

before marriage. Sex before marriage is frowned upon in both rural and urban settings and a pregnant unmarried daughter brings dishonor to the family. We heard that mothers bear most the stigma and shame of a pregnant unmarried daughter

Insights ***Burkina*** ***Faso***



**PARENTS BEAR
THE SHAME:**
Though
parents bear
the shame of
an unplanned
pregnancy,
parents and
youths aren't
comfortable
talking
about sex,
puberty and
contraception.

PARENTS BEAR THE SHAME:

Though parents bear the shame of an unplanned pregnancy, parents and youths aren't comfortable talking about sex, puberty and contraception.

Punished for Prevention

“We went to one of the facilities and what interested me was, how do parents perceive a girl who is on contraception?”

The female provider told us that three days ago, a girl came back to the facility after being beaten by her brother and her father. Her brother noticed that she had an implant, so they beat her and kicked her out of the house. They told her she could only come back if she removed the implant. She stayed away for 3 days and then went to the facility and asked them to remove it. She was still in pain. The provider removed it not because she wanted to, but because the girl asked them to. They offered IUCD or injectables but she refused. The provider told her that they will not tell her mother. She left without even saying goodbye. This was because of the trauma she went through. I can understand.

—

Researcher, Burkina Faso.

Insights Providers



**“I FEEL COMFORTABLE
LEAVING THE FAMILY
PLANNING INFORMATION
AT HOME BECAUSE
THE SCHOOL GAVE
IT TO ME.”**

—
Young woman, Bobo-Dioulasso

Currently school comprehensive sexuality education is inadequate. Contraception information provided by schools is considered a trusted source by parents. Young people told us they can bring this home without fear of punishment by parents, compared

to if they brought back information from the clinic. Despite national policies that support SRH education in schools, we heard from youth and community leaders that sex education in schools varies widely and was generally of low quality.

Insights ***Burkina*** ***Faso***



**SCHOOLS ARE
ACCEPTABLE
CONDUITS OF
INFORMATION:
Sexual and
reproductive
information
shared from
the school
may be more
acceptable to
parents and
caregivers.**

**“IT’S UNACCEPTABLE
TO SEE A GIRL IN
HER PROCREATION
AGE AND NOT
HAVING CHILDREN.”**

Community Leader, Bobo-Dioulasso

Not only is she expected to be the image of the community being obedient to its members, but we heard that communities hold the belief that it is every woman’s duty to get married and have as many children

as possible. Youth lack detailed information about their rights and sexuality due to community taboos and contraception was not widely accepted by the community, especially for unmarried youth.

Insights ***Burkina*** ***Faso***



REPRODUCTIVE ROLE:

A young girl is under great pressure to fulfill the community’s expectations of her reproductive role as a woman.

Design Briefs

WE STARTED WITH THE BIG QUESTION:

How might we improve empathy and choice for young people seeking contraceptive information and services?

Based on what we've learned together in three countries from youth, providers, communities and experts, we've identified several opportunities for design. Here's our design questions to kick start our ideation together.

OVERARCHING DESIGN QUESTIONS

Fostering mutual value and empathy
between providers and youth

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

MAPPED INSIGHTS:

Stigma and Secrets – Youth ≠ Clients – Confidentiality is Key
– Youth Expect Little – Overworked – Shamed for Pregnancy,
Shamed for Preventing Pregnancy – Wearing Two Hats

Improving efficiency
and youth preparedness

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

MAPPED INSIGHTS:

Not Ready to Choose – Timing is Everything – Fertility First
– Too Much or Too Little – Confused Policy/Standards –
Reproductive Duty

Transforming quality
and accountability

How might we measure
and reward quality service
for youth?

MAPPED INSIGHTS:

Youth Expect Little – Youth ≠ Clients – Confused Policy/
Standards – Confidentiality is Key – Cost and Transparency –
Little to No Benefits – Prioritizing HIV – Low profit, High Risk

PAKISTAN:

How might we engage households in partnership to reduce providers' barriers to reaching young married women?

MAPPED INSIGHTS:

Clinic vs Community – Fertility First – Timing is Everything – CHWs are Expert Navigators – Reproductive Duty – Shamed for Pregnancy, Shamed for Preventing Pregnancy – Family Rules

TANZANIA:

How might we leverage peer to peer interactions to better prepare youth to visit a provider?

MAPPED INSIGHTS:

Clinic vs Community – Shamed for Pregnancy, Shamed for Preventing Pregnancy
– Not Ready to Choose – Bad News Travels Fast – Less They Know the Better

BURKINA FASO:

How might we integrate providers into a school setting to better reach youth and signpost them to services?

MAPPED INSIGHTS:

Clinic vs Community – Not Ready to Choose – Stigma and Secrets –
Schools are Acceptable Conduits of Info – Parents Bear the Shame – Cost Barrier

WHAT'S NEXT

Let's discuss!

Give us feedback please

We'll begin the Ideation
phase next week

Key Dates:

Ideation Preparation
for Ideation Leads
AUGUST 17th

Ideation Workshop
AUGUST 24–25th

Ideation Convening
SEPTEMBER 18–20th

Thank You

beyond bias >



y.labs

Appendix

PERSONAS

Prisca

Unmarried, 0 children, in education



“I don’t know what’s happening with my body, and I don’t know who to talk to.”

PROFILE

NAME: Prisca

AGE: 14

GENDER: Female

MARITAL STATUS:

Unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION:

Secondary school student

RELIGION: Islam

LOCATION: Morogoro

HOBBIES: Drawing, netball,
goes to madrasa

ASPIRATIONS: To be a doctor,
get married, have children
one day (around age 25),
make her parents proud

ACCESS TO CELL PHONE: None.
Only father has phone.

SRH DATA

SEXUALLY ACTIVE:

No

VISITED A CLINIC OR A PROVIDER:

No

FP METHOD(S) USED:

None

**KNOWLEDGE ABOUT FP/SRH
(ON A SCALE OF 0 TO 5):**



PAST EXPERIENCE:

With sex being a taboo in the community, Prisca’s family never talked about sex, puberty or menstruation. Prisca started her period, but she didn’t know where to learn about what’s happening to her body. Prisca only ever hears reasons not to have sex such as rape, so she has developed a fear of even approaching the subject in conversation.

NEEDS

- Information on body changes and menstruation.

PAIN POINTS

- Community: Fear of rape which can result in shame, friends are starting to talk about sex
- Family: Heavy expectations to protect family honor
- Providers: Not even thinking about clinic, and no idea how to access information about sex and contraception, given her age and parents’ opposition

BARRIERS

- Bringing shame on family
- Fear of rape or attack by boys
- Curious but timid to ask questions, started periods but so afraid since her mother told her nothing beforehand

PERSONAS

Holo

Unmarried, 1 child, out-of-school



“When you’re denied help over and over, you give up on asking for help at all.”

PROFILE

NAME: Holo

AGE: 17

GENDER: Female

MARITAL STATUS:

Single, unmarried

NO OF CHILDREN: 1

OCCUPATION & EDUCATION:

Small bites/snacks seller, secondary school drop out

RELIGION: Christian

LOCATION: Arusha

HOBBIES: Socializes with friends, parties, listening to music, cooking

ASPIRATIONS: Go to university, to be an accountant, have a good family life

ACCESS TO CELL PHONE: Yes

SRH DATA

SEXUALLY ACTIVE:

Yes

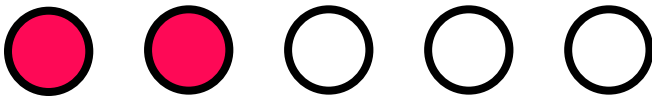
VISITED A CLINIC OR A PROVIDER:

Yes

FP METHOD(S) USED:

None

KNOWLEDGE ABOUT FP/SRH (ON A SCALE OF 0 TO 5):



PAST EXPERIENCE:

After having an early unexpected pregnancy, Holo was forced out of her home and school. The entire community shamed her by labeling her as a prostitute. A provider forced her to have an HIV test then offered her condoms only, saying she was ‘high risk’ for HIV. Holo didn’t receive any information about other methods.

NEEDS

- Long-term acting contraception (IUCD) in order to avoid unwanted pregnancy, so that her educational aspirations will not be compromised.

PAIN POINTS

- Community: Stopped supporting her after the unexpected pregnancy, considered her as a prostitute, peers see her as a failure
- Family: Wanted her to marry, shame her for not listening to family values, abandon after pregnancy
- Providers: Abortion is illegal, high financial cost of services, no empathy from providers

BARRIERS

- Early unexpected pregnancy
- School drop out
- No money for private school or services
- Own independence but it deviates from peer and family values

PERSONAS

Chris

Unmarried, 0 children, educated



“Where are we supposed to learn more? I can’t trust the internet and my friends don’t know much more than me. I don’t want a baby at my age.”

PROFILE

NAME: Chris

AGE: 17

GENDER: Male

MARITAL STATUS:

Single, unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION:

Student

RELIGION: Christian

LOCATION: Kigamboni,
Dar es Salaam

HOBBIES: Traditional dance,
music, social media

ASPIRATIONS: Study
abroad, be a musician

ACCESS TO CELL PHONE: Yes

SRH DATA

SEXUALLY ACTIVE:

Yes

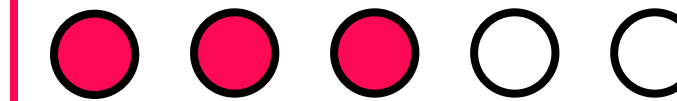
VISITED A CLINIC OR A PROVIDER:

Yes

FP METHOD(S) USED:

Male condom

**KNOWLEDGE ABOUT FP/SRH
(ON A SCALE OF 0 TO 5):**



PAST EXPERIENCE:

Chris tends to use the internet to ask questions about sex. His older friends tell him scare stories about contraception and condoms – “they’ll give you cancer of the penis.” His best friend got a girl pregnant and had to find money so she could have an abortion in secret. She was sick afterwards. Chris wants to do the right thing by his girlfriend, but sometimes they forget condoms.

NEEDS

- Access to SRH information
- Support his girlfriend in getting contraceptive services

PAIN POINTS

- Community: overall opposition to premarital sex, peer pressure to engage in sex at a young age with many partners
- Family: Lack of open discussion about sexual health and relationships outside the intent to marry
- Providers: Limited to no access to SRH information due to his age

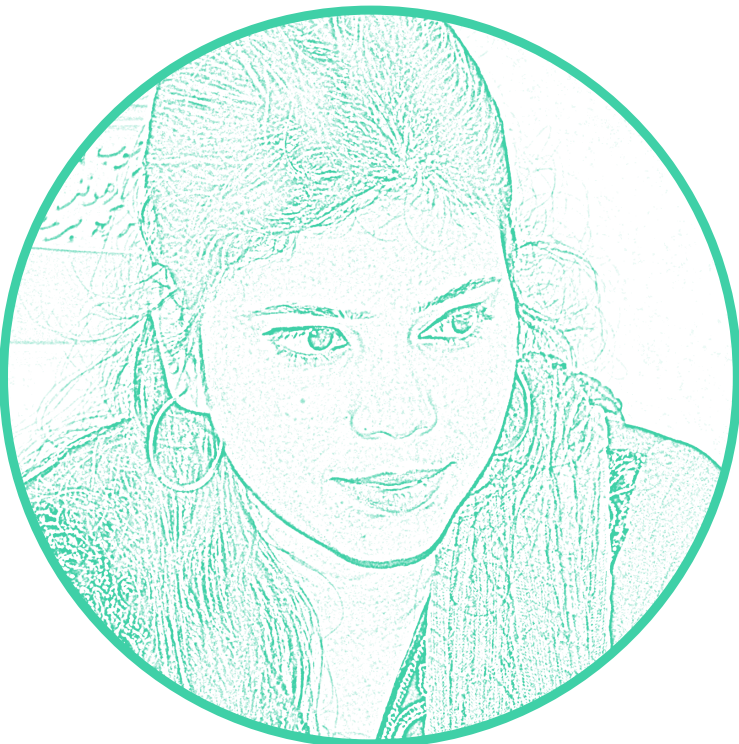
BARRIERS

- Lack of access to accurate SRH information
- Judgement for his age and marital status
- Concerns over the use of contraceptives due to misinformation and myths passed around by peers

PERSONAS

Farwa

Unmarried, no children, university-educated



“When a woman who isn’t ready has a child, it’s not a blessing to the one giving birth and the one who’s been born. Children should be born out of love. Not out of societal conventions or familial obligations. Perhaps one day I may have a child. But today, tomorrow, and for the rest of my life – I am a woman who refuses to compromise my aspirations.”

PROFILE

NAME: Farwa Ali

AGE: 25

GENDER: Female

MARITAL STATUS:
Single, unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION:
University student, BA

RELIGION: Islam

LOCATION: Nazimabad, Karachi

HOBBIES: Reading books, travelling

ASPIRATIONS: Academically ambitious, intends on gaining a PhD and teach at a university. Lives independently.

ACCESS TO CELL PHONE: Yes

SRH DATA

SEXUALLY ACTIVE:
Yes

VISITED A CLINIC OR A PROVIDER:
Yes, in a large well known hospital.

FP METHOD(S) USED:
Emergency Contraception

KNOWLEDGE ABOUT FP/SRH
(ON A SCALE OF 0 TO 5):



PAST EXPERIENCE:
After learning more about family planning, Farwa decided to switch from using EC to IUCD. She visited a provider, but was refused service for being a single unmarried woman with no children.

NEEDS

- Long-acting contraception (IUCD) in order to avoid unwanted pregnancy, and achieve her educational aspirations

PAIN POINTS

- Community: Gender norms that don’t allow a woman to live independently
- Family: Her contraceptive needs conflict with her family’s religion, sense of honor, and expectations to marry and have first child immediately
- Providers: Lack of information for unmarried youth, cross examination by older clients in waiting room, refusal to provide contraception as she is a young unmarried, nulliparous woman

BARRIERS

- Family’s conservative views and expectations
- Community norms
- Expectations to marry and have children
- No informational structure in place for unmarried youth
- Religion

PERSONAS

Madeeha

Married, no children, secondary school-educated



“I wasn’t supposed to go to the clinic without my husband or mother-in-law. But I knew they would refuse to accompany me. So, I went alone, but was still denied. It’s risky for me, but I need to protect my dreams.”

PROFILE

NAME: Madeeha

AGE: 21

GENDER: Female

MARITAL STATUS:
Newly married (6 months)

NO OF CHILDREN: 0

OCCUPATION & EDUCATION:
Housewife, intermediate

RELIGION: Islam

LOCATION: Karachi, Pakistan

HOBBIES: Cooking, watching TV and Indian movies

ASPIRATIONS: Gain more education, build a happy, prosperous and smaller family

ACCESS TO CELL PHONE:
Occasionally. Uses husband’s cell phone when needed.

SRH DATA

SEXUALLY ACTIVE:

Yes

VISITED A CLINIC OR A PROVIDER:

Yes

FP METHOD(S) USED:

Pills, condom

KNOWLEDGE ABOUT FP/SRH (ON A SCALE OF 0 TO 5):



PAST EXPERIENCE:

Madeeha visited a clinic without her husband or his family knowing. She was denied any services when the provider demanded she must fulfill her duty as a married woman by having her first child.

NEEDS

- Delay pregnancy to go to university

PAIN POINTS

- Community: Needs to prove her fertility through childbirth, being scrutinized by family, husband and relatives
- Family: In-laws expect her to abandon her educational plans and have children. They expect the first child within 1-2 years after marriage.
- Providers: Not receiving services and information from LHWs, CHWs and providers as they don’t see her as a client until she’s had her first child

BARRIERS

- Restricted mobility due to her husband, mother-in-law, and his family not allowing her to travel alone
- Fear that LARCs cause infertility among providers

PERSONAS

Mariam

Married, 4 children, uneducated



“I want to be a good mother who can give the best quality of life to my children. But the more children I have, the harder things will be for my family.”

PROFILE

NAME: Mariam

AGE: 22

GENDER: Female

MARITAL STATUS:
Married

NO OF CHILDREN: 4

OCCUPATION & EDUCATION:
Housewife, uneducated

RELIGION: Christian

LOCATION: Nazimabad Karachi

HOBBIES: Cooking,
stitching clothes

ASPIRATIONS: Envisions an independent house with no pressures from mother-in-law and other family members, live happily with a smaller family with good education of her children.

ACCESS TO CELL PHONE: Y

SRH DATA

SEXUALLY ACTIVE:
Yes

VISITED A CLINIC OR A PROVIDER:
Yes, in a large well known hospital.

FP METHOD(S) USED:
None

**KNOWLEDGE ABOUT FP/SRH
(ON A SCALE OF 0 TO 5):**



PAST EXPERIENCE:

Since raising a large family would be financially difficult, Mariam attempted to access contraceptive services but was denied. After having 2 children, the providers denied her a method again in fear of damaging her fertility. After more unexpected pregnancies, the provider recommended sterilization since she now had 4 children.

NEEDS

- Long acting method to avoid unplanned pregnancy, since she doesn't want to have any more children.

PAIN POINTS

- Community: Community norms, discrimination against her for religion and minority status
- Family: Possible expectation to have more children
- Providers: Fee charges for services, lack of information on methods other than injection and sterilization

BARRIERS

- Discrimination against her religion
- Minority status within the community
- Financial charges
- Fear of discrimination

PERSONAS

Cedric

Unmarried, 0 children, university-educated



“I love her, so I’m going to protect her. I’m not going to jeopardize both of our futures by making us parents when we’re not ready.”

PROFILE

NAME: Cedric

AGE: 20

GENDER: Male

MARITAL STATUS:
Unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION:
University student

RELIGION: Christian

LOCATION: Ouagadougou

HOBBIES: Reading, playing or watching football, spending time with girlfriend

ASPIRATIONS: To be a lawyer

ACCESS TO CELL PHONE: Yes

SRH DATA

SEXUALLY ACTIVE:

Yes

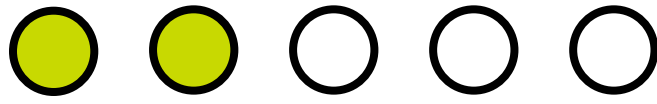
VISITED A CLINIC OR A PROVIDER:

Yes

FP METHOD(S) USED:

Male condom

KNOWLEDGE ABOUT FP/SRH
(ON A SCALE OF 0 TO 5):



PAST EXPERIENCE:

Cedric and his girlfriend went to a clinic together. They were shamed every step of the journey from the waiting room to the provider interaction. Not only did the provider later tell their parents about how they tried getting services, but their friends betrayed them by spreading news around the community.

NEEDS

- Help his girlfriend acquire a long-acting contraceptive method so that they may avoid unwanted pregnancy while both attending university

PAIN POINTS

- Community: Peers judge him for supporting contraceptive use, community doesn’t acknowledge youth opinions
- Family: Doesn’t understand why he’s with a girl whom he’s not married to, disapproves of them trying to access contraceptive services since it implies they’re sexually active, without intending to have a child
- Providers: Shame young unmarried couple for seeking contraceptive services, threatens to tell their parents

BARRIERS

- Financial cost of clinic services
- Gender norms and expectations
- Community judgement
- Lack of confidentiality

PERSONAS

Alima

Unmarried, 1 child, educated



“Why doesn’t our community see what can happen when a woman is denied contraception? Don’t they see how they’re doing more harm than good?”

PROFILE

NAME: Alima

AGE: 17

GENDER: Female

MARITAL STATUS:
Single, unmarried

NO OF CHILDREN: 1

OCCUPATION & EDUCATION:
School dropout, fruit seller

RELIGION: Islam

LOCATION: Dayoubsi

HOBBIES: Go to cinema, music

ASPIRATIONS: To open a restaurant one day, send her daughter to a good school

ACCESS TO CELL PHONE: Yes

SRH DATA

SEXUALLY ACTIVE:

Yes

VISITED A CLINIC OR A PROVIDER:

Yes

FP METHOD(S) USED:

Pills after childbirth. Stopped once no longer having a partner.

KNOWLEDGE ABOUT FP/SRH
(ON A SCALE OF 0 TO 5):



PAST EXPERIENCE:

When Alima became pregnant two years ago, the community shamed Alima and her mother in public. She had to find her own means of survival. From this experience, Alima sought out contraception to avoid unexpected pregnancies. But her clinic visits were unsuccessful. She was judged and shamed by providers for her past actions.

NEEDS

- Long acting contraceptive method to avoid any more future unexpected pregnancies

PAIN POINTS

- Community: Gender norms that don’t allow a woman to live independently
- Family: Abandoned her after she had an unexpected pregnancy
- Providers: Judges her for requesting contraceptive services as an unmarried woman, demands abstinence by using her past teenage pregnancy as an example of her bad behavior

BARRIERS

- Lack of financial resources
- Limited educational opportunities
- Ongoing community shame and judgement
- Not finding a partner for a stable relationship who accepts her daughter

PERSONAS

Sarata

Unmarried, 0 children, university-educated



“All my friends said it’s a waste of time to go to a clinic. Providers won’t help girls like us. I still needed to see for myself. My friends were right.”

PROFILE

NAME: Sarata

AGE: 21

GENDER: Female

MARITAL STATUS:
Single, unmarried

NO OF CHILDREN: 0

OCCUPATION & EDUCATION:
University student

RELIGION: Islam

LOCATION: Dassasgho

HOBBIES: Visiting cyber cafes, clubbing with her friends

ASPIRATIONS: To be a doctor, have a consistent monthly income

ACCESS TO CELL PHONE: Yes

SRH DATA

SEXUALLY ACTIVE:
Yes

VISITED A CLINIC OR A PROVIDER:
Yes

FP METHOD(S) USED:
None

KNOWLEDGE ABOUT FP/SRH
(ON A SCALE OF 0 TO 5):

PAST EXPERIENCE:
When Sarata became sexually active, she decided to visit the clinic for more information on contraception and possibly get services. Her friends discouraged her by saying providers won’t help unmarried women without children. Some spoke from personal experience. Sarata still went to the clinic, but was refused services for the same reason.

NEEDS

- Long term contraceptive method while focusing on education and pursuing career

PAIN POINTS

- Community: Pressure on young women to marry and have children, strong stigmatization of premarital sexual exploration or experience
- Family: She has to keep everything a secret from her family, even her brother in fear of punishment or abandonment.
- Providers: Lack of confidentiality in the clinic, rude and judgmental attitude, fear of pain and stress.

BARRIERS

- Family, community and provider expectations of marrying and childbirth increases opposition towards contraception
- Skepticism causing peers to discourage contraception use
- Limited information

GLOSSARY

AYSRH: Adolescent and youth sexual and reproductive health

CHW: Community health worker

D&C: Dilation and curettage, a procedure to remove tissue from inside the uterus, may be used to describe surgical abortion

IUCD / IUD: Intra-uterine contraceptive device or intra-uterine device

LAM: Lactational amenorrhoea

LARC: Long-acting reversible contraception

Menarche: the first menstrual period

PMTCT: Prevention of mother to child transmission

SRH: Sexual and reproductive health

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