MPT Acceptability in Uganda, Nigeria and South Africa
Understanding The Women, The End User

PREPARED FOR CAMI HEALTH & AVAC WEBINAR I 12TH NOVEMBER 2014

AGENDA
Content of discussion

DEDICATION – Moushira	1 min
CONTEXTULISING THIS WORK – Moushira	4 mins
METHODOLOGY – Jeff Lucas	6 mins
What we did & Where Who we listened to & How we did it	
Quantitative FINDINGS – Moushira	30 mins
SNAPSHOTS 10 mins: Demographics	
SNAPSHOTS 10 mins: Sexual Behavior	
SNAPSHOTS 10 mins: Pregnancy & Contraceptives	
SNAPSHOTS 10 mins: HIV & Testing	
MPT Profiles & Acceptability	20 mins
Discussion – Moderated by Bethany & Manju	15 mins

DEDICATION – Moushira	1 min
CONTEXTULISING THIS WORK – Moushira	4 mins

INTRODUCTIONS

Some names, some faces

Work led by:

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Neil Tierney
Senior Graphic Designer, Ipsos

DEDICATION

To all the young adolescent girls and women who we listened to …

Funded by

BILL & MELINDA GATES *foundation*

CONTEXTUALISING THIS WORK

An essential part of the story

This type of work is vital – understanding the end user (at a nationally representative level) **and their perceptions and level of demand** (based on profiles not marketing etc…) is essential to ensuring that products in development are relevant and meaningful to the people who are going to use it

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Our objectives were two-fold

1. To understand women in Uganda, Nigeria & South Africa in relation to their environment, sexual behavior, pregnancy & contraceptives and HIV & risk
2. To gauge the level of acceptability for the concept of dual protection and for 4 MPT profiles

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Much can be built upon this research

- The importance of understanding different countries – women in Africa do not lead the same life, countries differences are important to appreciate
- Developing a full forecasting model – incorporating full market dynamics
- Communications and message development
- Future products that will be marketed need to be supported via greater understanding of what can be done to ensure optimization of their reach (including MPTs, and other non-MPT products i.e. TFV Gel and The DPV Ring)

METHODOLOGY – Jeff Lucas 6 mins

What we did & Where
Who we listened to
& How we did it

METHODOLOGY:

This works had two phases, this webinar will focus on the latter

1 Qualitative Phase

We qualitatively talked with 371 women, 72 men, 108 HCPs and 20 marketing executives

South Africa [Johannesburg, Cape Town & Durban], Uganda [Kampala, Gulu and Mbarara] and Nigeria [Lagos, Benue & Enugu]

Via

- Women: 90 minutes In-Depth Interviews (IDIs) s and 120 minutes Focus Group Discussions (FGDs)
- Men: 60 minute IDIs
- HCPs: 60 minute IDIs
- Executives: 45 minute IDIs

Benefits of qualitative

- Qualitative research aims to understand how the participants derive meaning from their surroundings, and how their meaning influences their behavior – it lets the meaning emerge from the participants.
- It gives the broad explanation of the 'why' and the 'how'. It is important to appreciate this point.

2 Quantitative Phase

We quantitatively surveyed 1,722 women

South Africa [additional region of Port Elizabeth], Uganda [additional region Mbale] and Nigeria [additional region Abuja]

Via

60 minute interviews

The place of quantitative research

- Quantitative research aims to understand the what – collecting numerical data to understand the phenomena
- It will be able to test hypotheses and with representative sample establish what is being done; understanding both cause and effect

METHODOLOGY: Quantitative phase

A nationally representative sample of women

Sample

- South Africa (n=519)
- Uganda (n=619)
- Nigeria (n=512)

Sampling:

Based on: age, Socio-Economic Class (SEC)/Living Standard Measure (LSM – for South Africa) & HIV prevalence (to select region with appropriate representation urban/rural split). Utilizing DHS and household surveys for all three markets when establishing population statistics and SEC

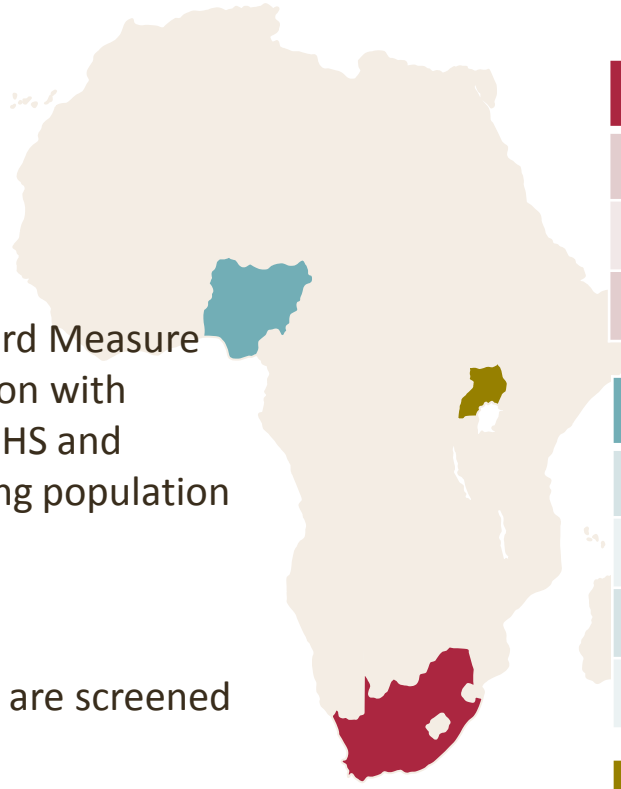
Recruitment:

Door-to-door recruitment, where potential respondents are screened and then interviewed those who qualified

Ethical Approval: All work received ethical approval from each country - Under 18s were not approved by SA

Data collection

- Face-to-Face (F2F) 60-minute interviews with women using mobile technology – more accurate
- Interviewers were briefed and trained in-field by us
- Interviews teams spoke local/regional languages



Age % Sampled

South Africa	
18-22yrs	29%
24-28yrs	37%
29-35yrs	34%

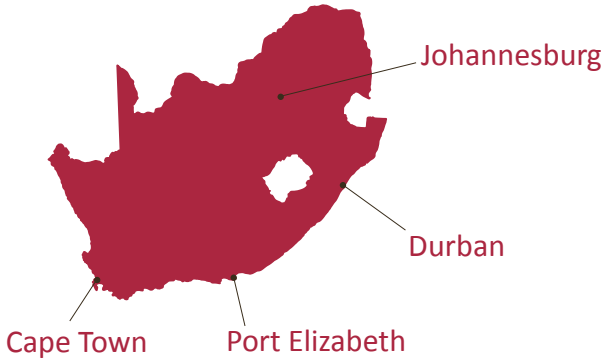
Uganda	
15-19yrs	27%
20-24yrs	31%
25-29yrs	21%
30-35yrs	22%

Nigeria	
15-19yrs	29%
20-24yrs	31%
25-29yrs	21%
30-35yrs	19%

METHODOLOGY: Regions - Urban/Rural split

A nationally representative sample of women

South Africa: mostly urban



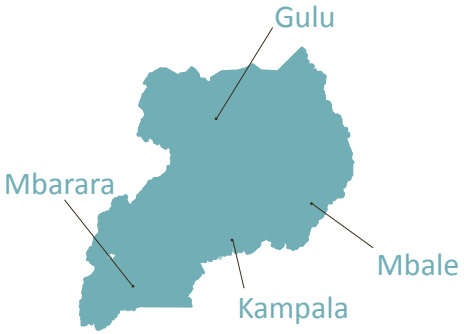
Johannesburg – 92% urban

Cape Town – 86% urban

Durban – 60% urban

Port Elizabeth – 54% urban

Uganda: mostly rural



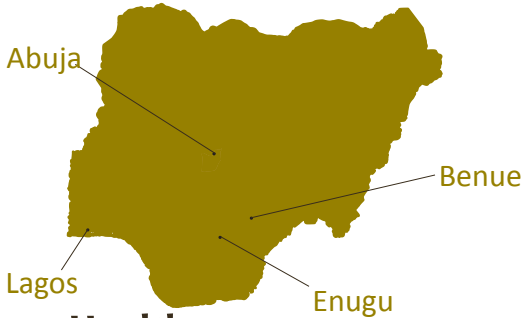
Kampala – 43% rural

Mbale – 85% rural

Gulu– 85% rural

Mbarara– 82% rural

Nigeria: split depending on region



Lagos – 95% urban

Abuja – 54% urban

Benue – 80% rural

Enugu– 81% urban

Age % Sampled

South Africa (n=519)	
18-22yrs	29%
24-28yrs	37%
29-35yrs	34%

Uganda (n=619)	
15-19yrs	27%
20-24yrs	31%
25-29yrs	21%
30-35yrs	22%

Nigeria (n=512)	
15-19yrs	29%
20-24yrs	31%
25-29yrs	21%
30-35yrs	19%

METHODOLOGY:

Screening information

Women were screened and had to fulfil the following criteria:

- Region
- Urban/Rural split
- SEC C1 and below /LSM 6-7 and below

- All nationally representative

Specific criteria for the research

- Age
  - South Africa: 18-35yrs
  - Uganda/Nigeria 15-35yrs [parental/guardian consent given for those under 18yrs]
- Is sexually active
- Not currently trying to conceive
- Not currently pregnant
- Consider herself HIV negative
- Currently/have used/intend to use contraceptive method(s) to prevent pregnancy
- Currently not using contraceptives but open to using them

Additional information captured in the screener

- Working status
- Relationship status
- No. of children
- Intention to conceive in the future
- Highest level of education attained
- Religion

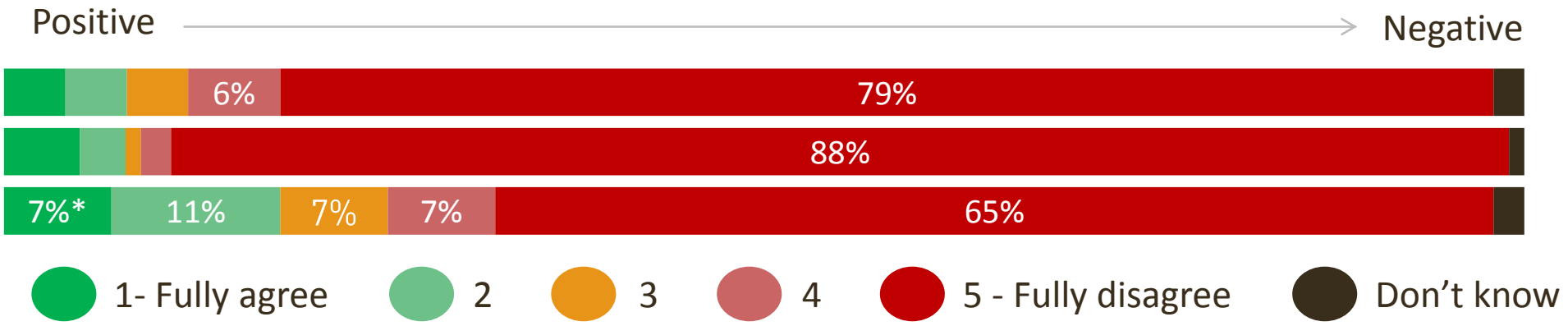
METHODOLOGY:

What we mean when we say … points to note …

1

5 point scale statements are used throughout the study from sexual behavior statements to HIV risk, as well as acceptability of side effects and MPT characteristics [1 would be fully acceptable and 5 completely unacceptable]

Those statements with 5 point scale with be noted throughout the presentation as at the bottom of the slide = [5 point scale]



2

Significance Testing at 95% significance

- Testing whether differences between groups are significant or not
- Shown by *
- Shown if one country, group is significantly different to rest

3

5% or lower
We do not show labels for percentages 5% and lower

Quantitative FINDINGS – Moushira 10 mins

SNAPSHOTS
10 mins

- Demographics
- Sexual Behavior
- Pregnancy & Contraceptives
- HIV & Testing

Quantitative FINDINGS – Moushira 10 mins

Demographics

WHO THE WOMEN ARE: Snapshot

The lives women live in Uganda, Nigeria & South Africa are very different

WOMEN WHO ARE NOT MARRIED BUT HAVE PARTNER

88%* South Africa

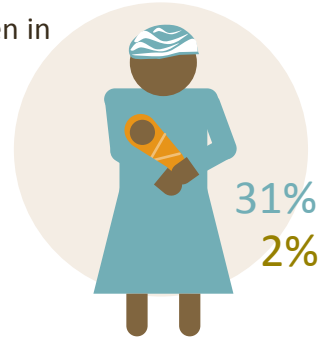
54% Uganda

58% Nigeria

SINGLE MOTHERS (WITH PARTNER)

Of the single women in South Africa…

74%* are mothers (66% population)



31% Uganda

2% Nigeria

EMPLOYMENT/EDUCATION/HOMEMAKERS (SELF DEFINED)

* = significantly more than other countries

Around **1/3** of women in all three countries are employed

Where women are unemployed it is because they are…

South Africa
- 54%* Looking for work
- 12%* Students

Uganda
- 24%* Homemakers
- 23% Students
- 17% Looking for work

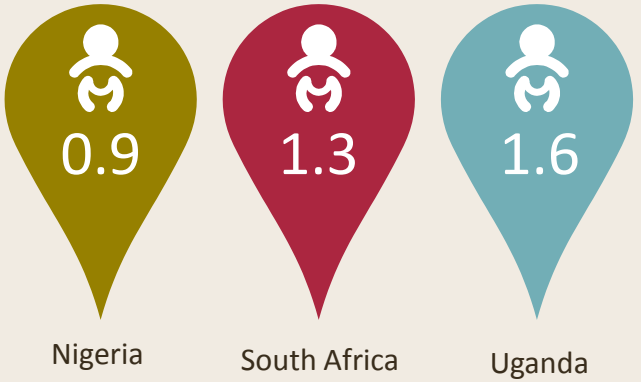
Nigeria
- 41%* Students
- 14% Unemployed
- 6% Homemakers

WHO THE WOMEN ARE: Snapshot

Women in South Africa have want fewer children with a larger gap between them

IDEAL AVERAGE NUMBER OF CHILDREN

AVERAGE # OF CHILDREN OUR SAMPLE HAD



52% 82% 80%

PLAN TO HAVE MORE CHILDREN

FERTILITY RATE (AVERAGE)†

SPACING: IDEAL GAP BETWEEN CHILDREN

South Africa: 4.1 yrs
Uganda: 3.4 yrs
Nigeria: 2.6yrs

†http://kff.org/global-indicator/total-fertility-rate/

* = significantly more than other countries

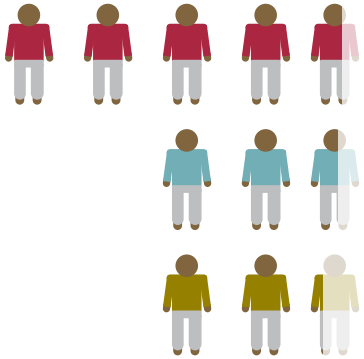
Quantitative FINDINGS – Moushira 10 mins

Sexual Behavior

SEXUAL BEHAVIOR: Snapshot

Women in South Africa are far more sexualized then their counterparts

AVERAGE # OF SEXUAL PARTNERS



4.6 South Africa

2.5 Uganda

2.3 Nigeria

AVERAGE # OF SEXUAL INTERCOURSES PER MONTH:

South Africa 11.2

Uganda 7.2

Nigeria 5.7

Married women are more sexually active in Uganda & Nigeria

OF SEXUAL PARTNERS

Almost

3/4

of women currently have one sexual partner

IF IN LT MONOGAMOUS RELATIONSHIP:

South Africa Uganda Nigeria

SEXUAL BEHAVIOR: Snapshot

Women in South Africa are more likely to engage in different sexual acts which are risky

% OF WOMEN WHO **DO NOT** ENGAGE IN …

	Oral Sex	Dry Sex	Anal Sex
South Africa	31%	49%	65%
Uganda	72%*	68%*	88%*
Nigeria	50%	52%	79%

Definitions used:
Oral sex: sexual activity in which the genitals of one partner are stimulated by the mouth of another (where the man or woman uses their mouth to lick/suck the vagina or penis)
Dry sex: sexual intercourse without vaginal lubrication (where the woman does not get wet, and remains dry for sex)
Anal sex: sexual activity involving the penetration of the anus (where the penis is inserted into the buttock)

[5 point scale]

* = significantly more than other countries

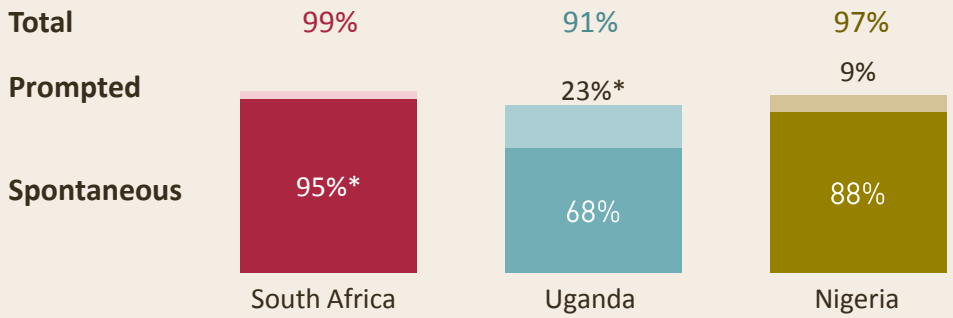
Quantitative FINDINGS – Moushira 10 mins

Pregnancy & Contraceptives

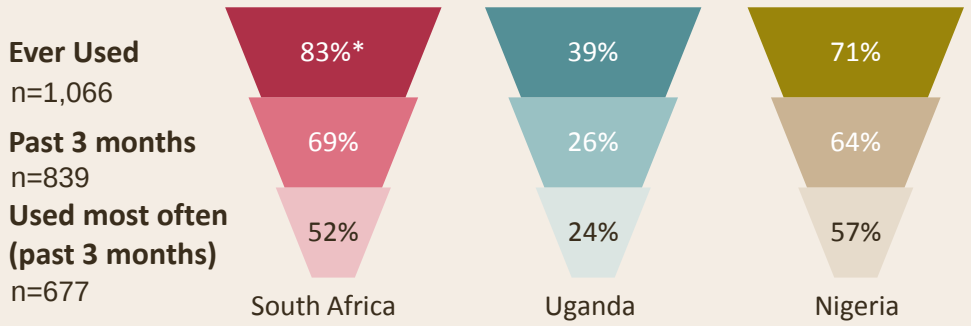
PREGNANCY & CONTRACEPTIVES: Snapshot

Despite overall high levels of awareness of the male condom, this does not translate into high levels of use
More women in South Africa and Uganda use the injection – motherhood activates the use of the injection

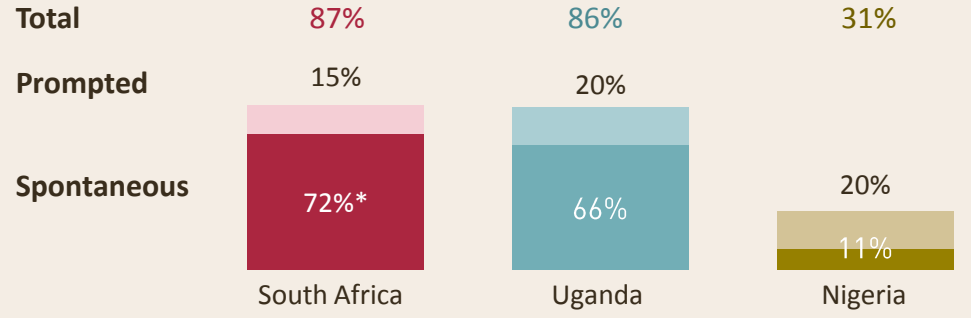
Awareness & Usage of Male Condoms



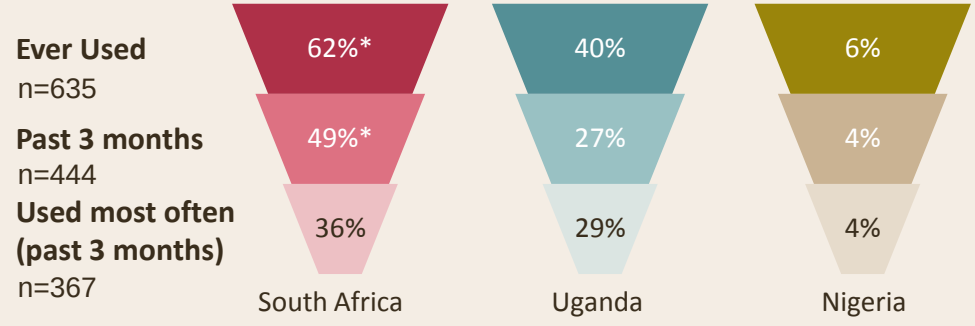
Usage of Male Condoms



Awareness & Usage of Injection



Usage of Injection



Note: Values ≤5% is not labelled
* = significantly more than other countries

PREGNANCY & CONTRACEPTIVES: Snapshot

More natural methods are likely to be part of the contraceptive set for women in Uganda and Nigeria. However, usage of other methods remains low and dispersed

South Africa

After male condoms and the injection…

Awareness of other methods

- Female condom (82%*)
- OCPs (81%)
- Abstinence (59%)
- Withdrawal (40%)

Usage

However, this level of awareness translates into minimal usage

- In particular for, the female condom (n=1)
- OCP (Ever used 27%*, Last 3 months 11%* and Most often used 6%)

Uganda

After male condoms and the injection…

Awareness of other methods

- OCPs (82%)
- Abstinence (68%*)
- Contraceptive implant (63%*)
- Timing/safe days (62%)
- Female condoms (60%)
- Withdrawal (56%)
- Timing after giving birth (53%*)
- ECPs (40%)

Usage

With this broader awareness of a range of contraceptives, usage is dispersed

- Ever used: range 18%-4%
- Last 3 months: range 10%-3%
- Most often used: range 8%-2%

Nigeria

After male condoms…

Awareness of other methods

- Withdrawal method (62%*)
- Timing/Safe days (58%)
- Female condoms (46%)
- Abstinence (45%)
- ECPs (44%)
- OCPs (43%)

Usage

Experience of contraceptives revolves primarily around 3 methods:

- Withdrawal: 29%*
- Timing: 22%*
- ECP: 18%*

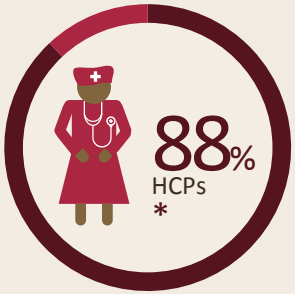
Experience of contraceptives revolves primarily around 3 methods, with other methods under7%.

PREGNANCY & CONTRACEPTIVES: Snapshot

It will be critical to understand which sources of information women rely on most when communicating MPTs

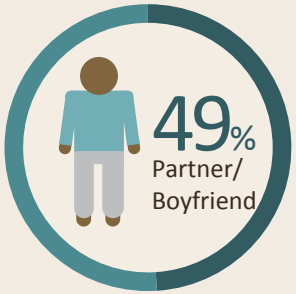
SOURCES OF INFORMATION FOR CONDOMS

South Africa



65% Family and friends
42% Media
27% Local Edu & Org
12% Partner/ Boyfriend

Uganda



43% Family and friends
33% Local Edu & Org
14% Media
14% HCPs^

Nigeria

37% Media
32% Partner/ Boyfriend^^
29% HCPs
26% Local Edu & Org

^In Uganda, when finding out about the injection the majority of women seek advice from Healthcare professionals as well
^^ In Nigeria, with regard to the withdrawal method the male partner is nearly exclusively the source of information

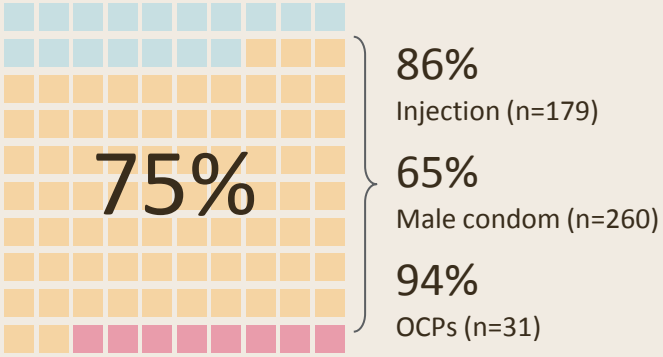
* = significantly more than other countries

PREGNANCY & CONTRACEPTIVES: Snapshot

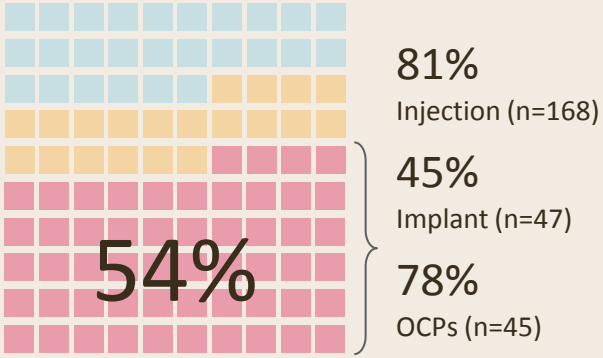
Overall, South African women get their contraceptives at no cost, whereas women in Uganda more commonly pay and more partners in Nigeria pay - the power dynamics between partners plays a large role

WHO PAYS?

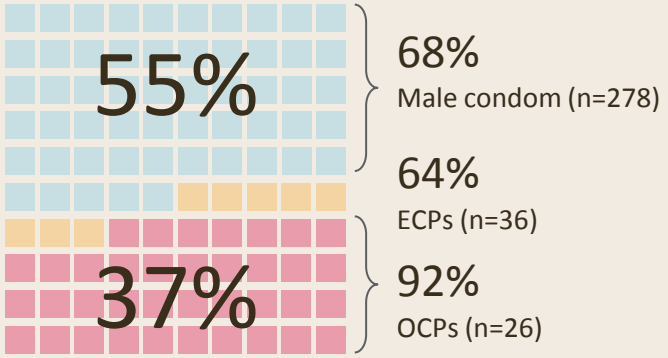
South Africa



Uganda



Nigeria



% of women | Partner Pays | No cost to me | I pay

* = significantly more than other countries

WHAT WOMEN WANT

Ideal contraceptive women would create *(from qualitative phase)*

Ideal contraceptive would have following characteristics

Good duration	Convenience/ Ease of use	Low/ no Side effects
▪ Some cannot get pregnant ▪ Sex can be unplanned (married women in particular) ▪ Need flexibility – fertility ▪ Good duration can mean long term protection for some – convenience or short term protection for others	▪ Not having to worry (South Africa in particular) ▪ Good duration – not frequent ▪ Ease of use – some mean self-administration (younger women in particular Nigeria/do not want to interact with HCP ▪ Lack of discomfort – do not like inserting into vagina	▪ Bleeding = questions fertility ▪ Partner will start questioning use ▪ Women who use the condom, safe days or timing mainly do so (and dual protection of condoms) as have no side effects/natural ▪ All HCPs state side effects can interrupt or cause cessation in use, reports of SEs from other women prevent trial

Ideal contraceptive would be:

- **An injection - 3 months to 5 years duration of protection**
- **A pill - 2 weeks to 1 year duration of protection**
- **A drink/liquid – mostly before sex**
- **A gel - to rub on before sex (mostly in the vagina)**

IN THEIR OWN WORDS

The ideal contraceptive …

South Africa	Uganda	Nigeria
1. Drink/Liquid	1. Injection	1. A pill
2. A pill	2. A pill	2. Drink/Liquid
3. Injection	3. Gel	3. Gel
4. Gel (very few)	4. Drink/Liquid	4. Injection

I would say if you drink water you will not fall pregnant because I think it is the easiest for everyone. Some people do not like to go to the clinic; so drinking water every day, you will not fall pregnant and you will get healthy too

An injection – I am sticking to what I know

A tea that you drink daily. The tea will stop the ovaries from being fertilised and would be drunk once a day in the morning.
It would not lead to weight gain and have no after effects/side effects.

It would be in form of a jelly in that you just smear and it melts in the vagina. This would last a week

One injection for a month that I would get at a hospital

A liquid packed in a tube that we can put into the vagina that lasts 24 hours

1) In powdered form
2.) Taken after sex after being mixed with water
3.) And you can even mix it with pap
4.) No side effect

Note: Pap is made from corn (corn paste), just like custard

I will create a drug, a tablet. It would be different from the one I am using because you would use it once in a month

What I will do with the wand is to stop the sperm from coming inside, I will produce a pill like the Postinor which will not have side effect and the frequency of use will be higher at a given period unlike Postinor which is 4 times in a month, but if exceeded, different symptoms will begin to surface.

Quantitative FINDINGS – Moushira 10 mins

HIV & Testing

HIV Prevention: Snapshot

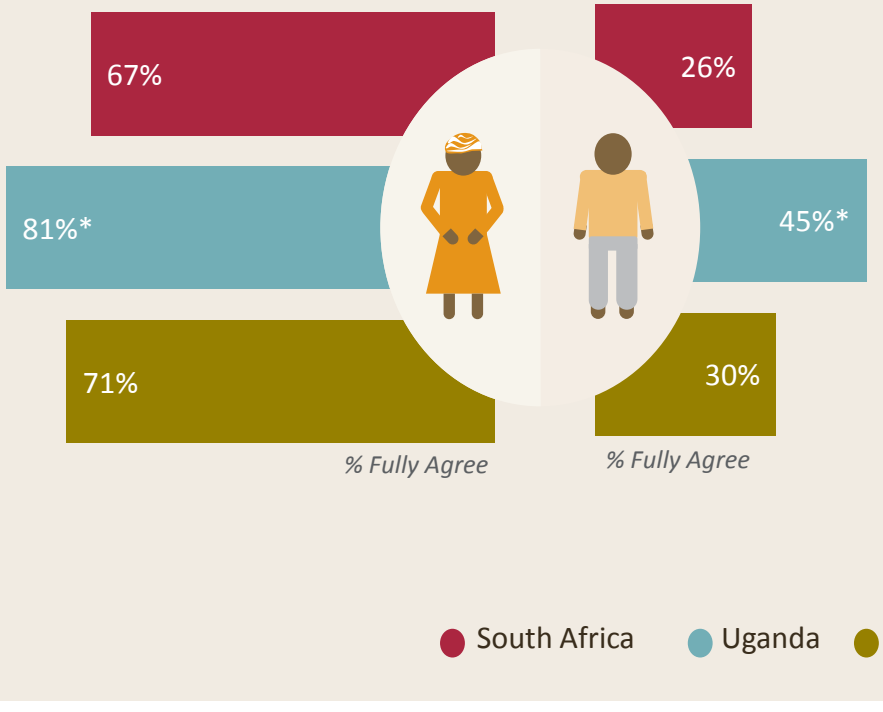
Male condoms are recalled as the main method to prevent HIV. The place of methods such faithfulness and then abstinence are higher in Nigeria and Uganda.
Significantly more women in Uganda claim to be faithful, compared to those in South Africa and Nigeria. Despite the majority claiming faithfulness, women are less sure that their partners are faithful

USAGE OF HIV PREVENTION METHODS:

	South Africa	Uganda	Nigeria
Ever used	**91%** **Male condom**	53% Faithfulness 50% Male condom	**72%** **Male condom** 46% Faithfulness
P3M	**84%** **Male condom** 19% Faithfulness	**50%** **Faithfulness** 37% Male condom	**69%** **Male condom** 43% Faithfulness
Most Freq. P3M	**83%** **Male condom** 9% Faithfulness	**47%** **Faithfulness** 32% Male condom	**62%** **Male condom** 32% Faithfulness

PRACTICE OF FAITHFULNESS (HER – HIM)

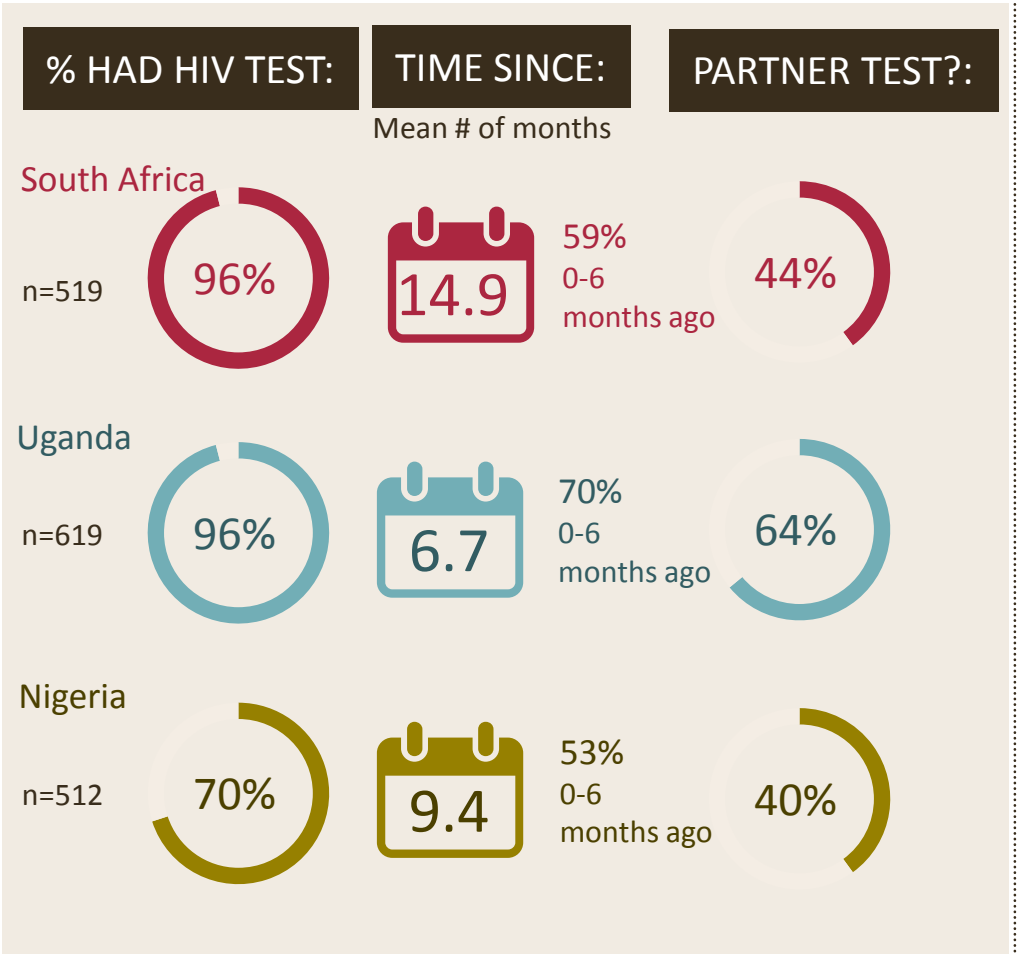
Faithfulness - a sexually exclusive relationship, one that is monogamous (only 1 partner) does not engage in sexual relationships outside of the marriage



* = significantly more than other countries

HIV TESTING: Snapshot

More women getting tested in South Africa and Uganda than Nigeria and poor awareness of partner testing overall
Nigerian women are impacted by their lack of interaction with healthcare world – current contraceptive methods used mean they do not need to engage with it and it is not a major source of information …



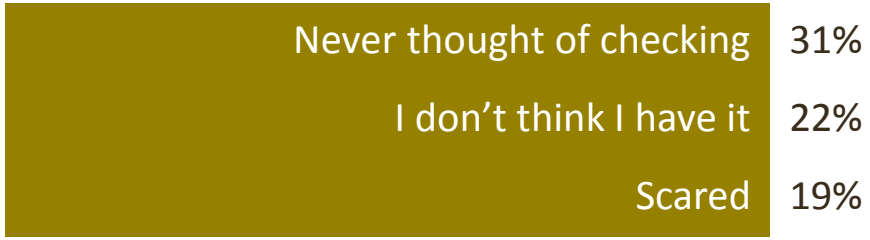
Those that know their partner has been tested (fully agree with statement)

[5 point scale]

TOP THREE REASONS FOR TESTING:

	Just to know	Pregnant	Felt sick
South Africa	38%	17%	10%
Uganda	51%	16%	9%
Nigeria	31%	13%	9%

30% Nigerian women not tested … because: top three



* = significantly more than other countries

HIV TESTING: Snapshot – Nigeria

Nigerian women are impacted by their lack of interaction with healthcare world – current contraceptive methods used mean they do not need to engage with it and it is not a major source of information …

Important reasons from this work that may explain why women in Nigeria are not getting tested as much as their counterparts in Uganda and South Africa are that:

1. There is a lower level of awareness around the importance of testing
2. Interaction with the healthcare professionals is more limited in Nigeria – fewer women are using contraceptives which require healthcare administration and fewer women are seeking advice about contraceptives and HIV from healthcare professionals compared to women in South Africa and Uganda
3. There is a sense of denial/fate with regard to acquiring HIV – mainly from the qualitative phase … in the sense that women either didn't think they could get it, or that it was not in their hands
4. There is also somewhat of a stigma with regards to testing – even being seen to be getting a test, some may assume the woman has HIV
5. Trust in healthcare facilities seems low – some women do not believe they would get correct results

Some ways of improving this situation include:

1. Education – creating platforms for community members to learn and inform each other on the importance of testing & efforts to reduce stigma of testing
   - May require outreach programmes
   - School programmes
2. Opening up a wider discourse on HIV in civil society
3. Increase availability of access of testing – illustrating also reliability of testing process to population
4. Improve perception of healthcare facilities via strengthening of their services

30% Nigerian women not tested … because: top three

Never thought of checking	31%
I don't think I have it	22%
Scared	19%

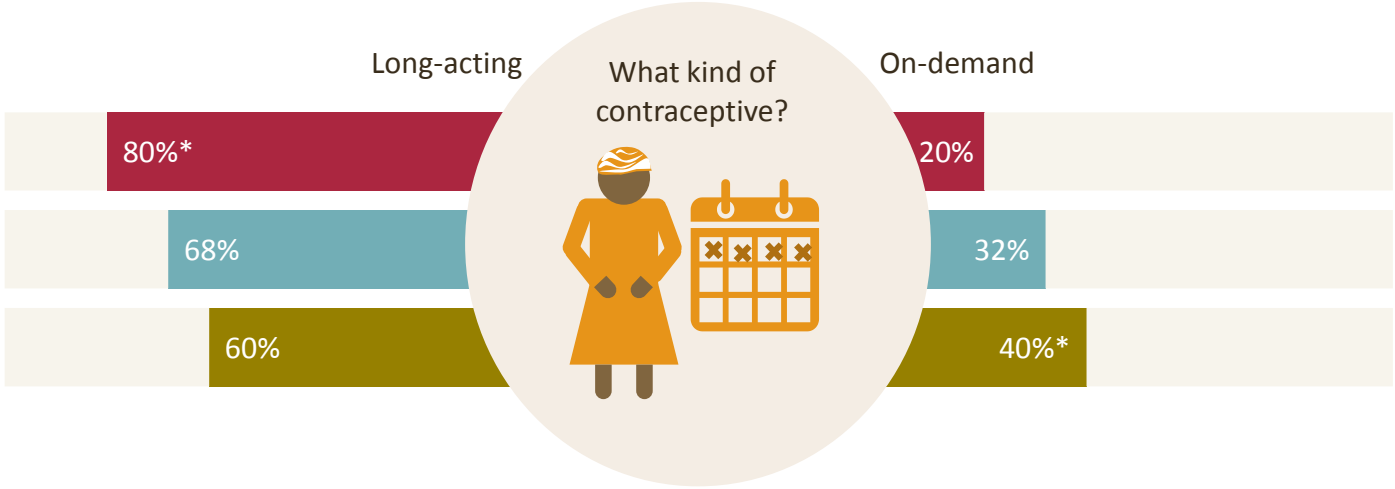
* = significantly more than other countries

Quantitative FINDINGS – Moushira	30 mins
SNAPSHOTS 10 mins: Demographics	
SNAPSHOTS 10 mins: Sexual Behavior	
SNAPSHOTS 10 mins: Pregnancy & Contraceptives	
SNAPSHOTS 10 mins: HIV & Testing	
MPT Profiles & Acceptability	20 mins

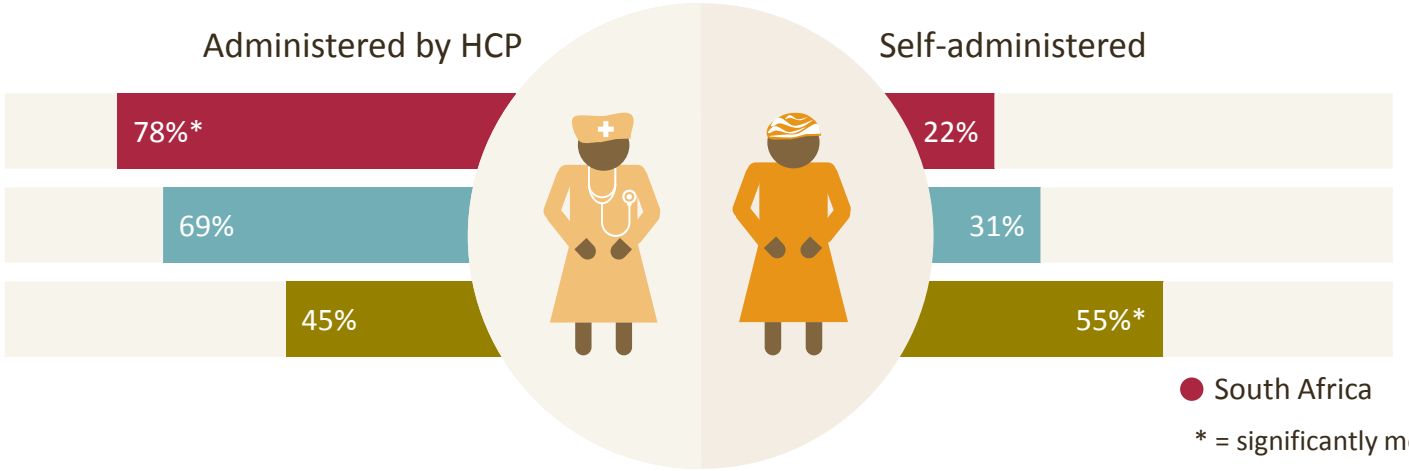
PREGNANCY & CONTRACEPTIVES: Snapshot

Longer-acting versus On-Demand & HCP-administered versus Self-administered

Long-acting or On-demand?



Self-administered or HCP-administered?



South Africa Uganda Nigeria

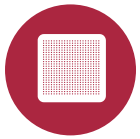
* = significantly more than other countries

MPT Form Profiles

1) We discussed the MPT concept 2) Read out profiles (randomized) with examples*

Common attributes

- 70% effective at preventing HIV infection and 85% (film) 95% (rest) effective at preventing pregnancy
- You will need to do a HIV test before and every 3 months during use
- There are no effects on daily lifestyle or your ability to work
- Not harmful to your body and is safe to use in the vagina
- If you were to become pregnant while using the MPTs, it will not harm the baby



INTRA-VAGINAL FILM

- Individual pouch
- Easy to tear open packet
- Can become pregnant once you stop using it
- Fold the film in half and insert it into the vagina using a finger.
- The film dissolves quickly inside the vagina.
- You insert one film up to 12 hours before sex and a second film up to 12 hours after sex
- It might cause vaginal irritation, itching, wetness or dripping

INTRA-VAGINAL RING

- Insert the ring into your vagina – squeeze the two sides together and then push the ring up high into your vagina. It cannot go anywhere else in the body, but might fall out if it isn't put in the right place or during certain activities
- You use the ring continuously for 60 days and then replace it
- It might cause vaginal itching or irritation. It may cause unpredictable, irregular, heavy bleeding, or no menstruation

INJECTABLE* no example

- Administered by trained healthcare worker
- Get it from a healthcare provider
- It is administered every 3 months as two injections – one in the arm and one in the buttock.
- It may cause bleeding irregularities – unpredictable, irregular, heavy bleeding, or no menstrual period.
- Once you stop getting the injection there is a 6-9 month period before you can conceive.

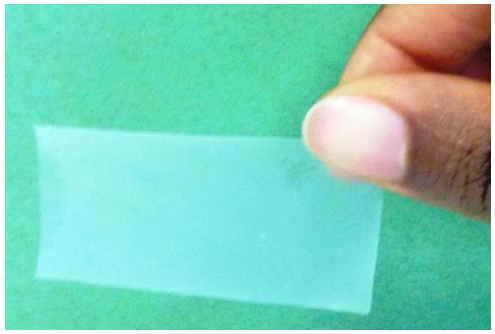
IMPLANT TYPE DEVICE

- Implants are inserted, following local anaesthesia (injection) with a trocar, not with a surgical incision.
- The two implants are first inserted at the same time. The HIV prevention rod will be changed every 6 months and the pregnancy prevention rod will be changed every 5 years.
- It may cause irregular bleeding during the first 6-9 months of use

MPT Form Profiles

Examples used …

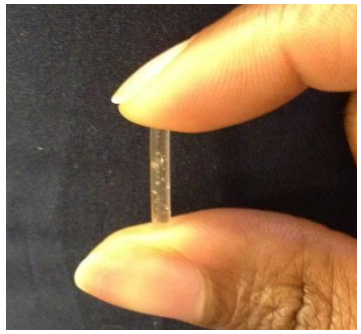
INTRA-VAGINAL FILM

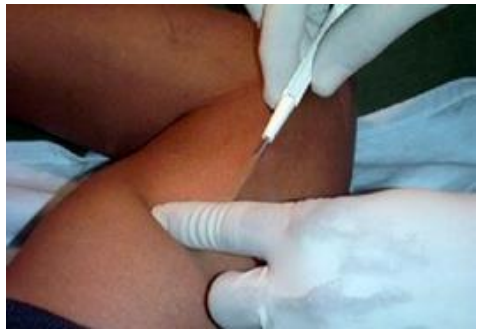


INTRA-VAGINAL RING

INJECTABLE* no example

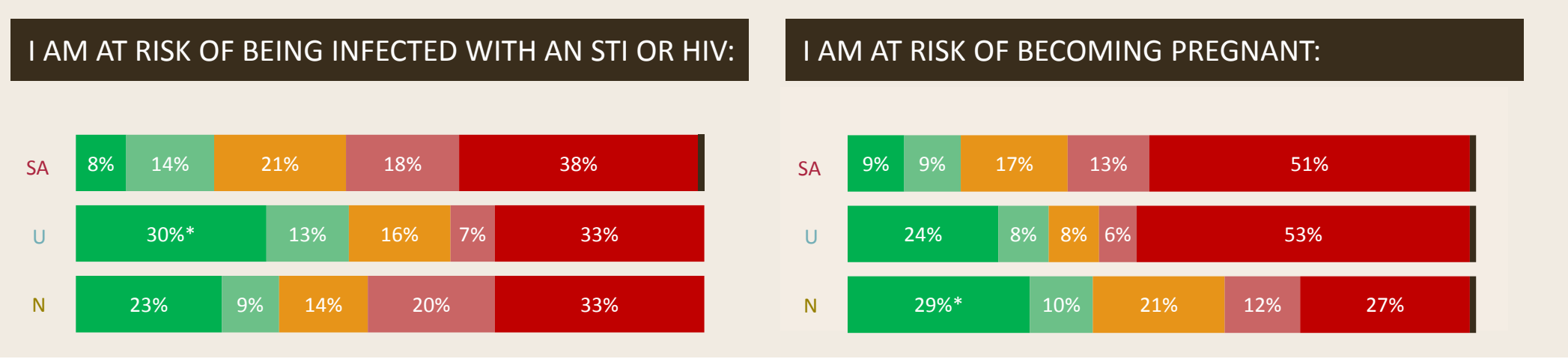
IMPLANT TYPE DEVICE



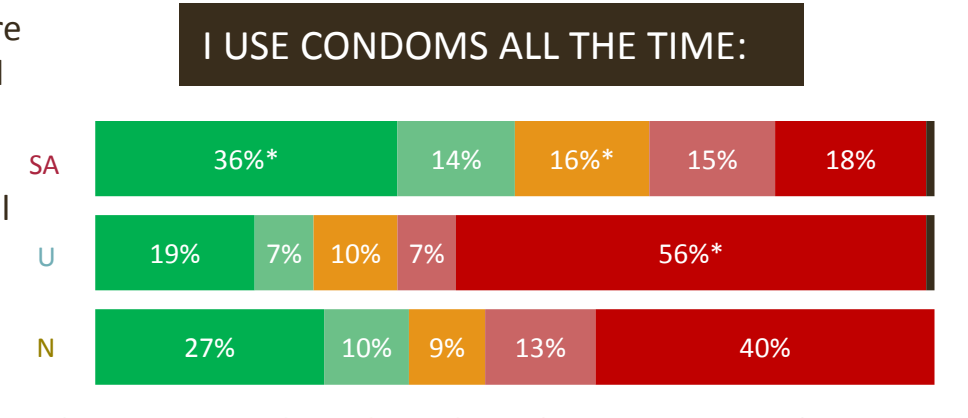


RISK PERCEPTION: Snapshot

Risk perception is a complicated story. However, women's risk perception is poor in most cases
The majority of women are at risk, regardless of their perception of risk – inconsistent condom use



- Women who have had an STI before feel more at risk (most haven't had one – lowered risk perception)
- Being in a LT monogamous relationship and one current sexual partners does not necessarily alleviate the feeling of risk
- Partner status does not improve perception
- Majority of women cannot say if their partner has been tested for HIV
- And even if they know their partner has been tested some women still feel at risk



Nigeria & Uganda:

- Inconsistent use: women who are married, living with their partner, homemakers, older women
- Consistent use: 15-18yr olds, those who are not married or living with their partner and those with fewer sexual partners

All:

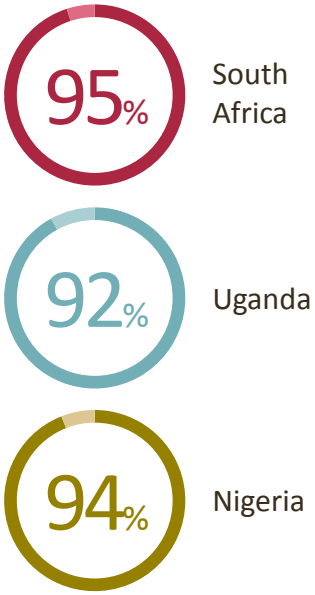
- ~2/3 of women state some level of difficulty with negotiating condom use with their partner

Note: Values ≤5% is not labelled
* = significantly more than other countries

MPT demand

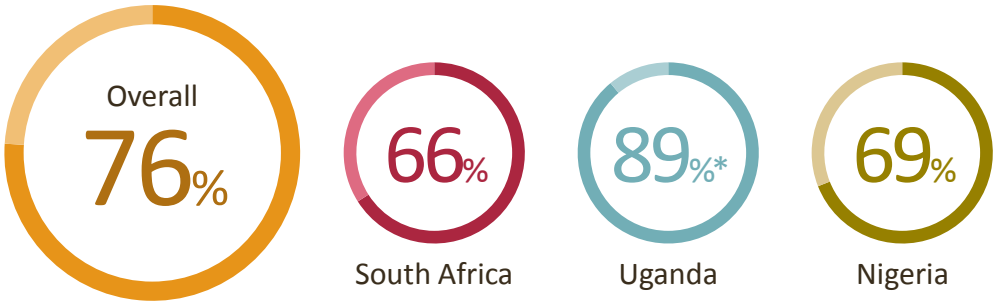
The concept achieved universal acceptance

THE MPT CONCEPT

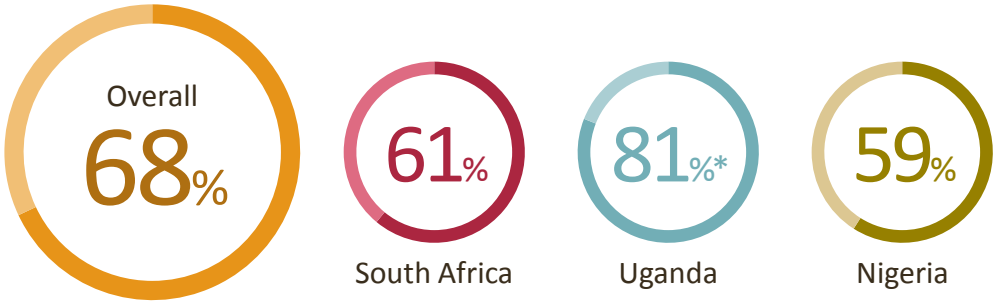


TESTING

How acceptable is having a HIV test before using a dual protection product?



How acceptable is having a HIV test every three months?



MPT form demand *if all forms are available*

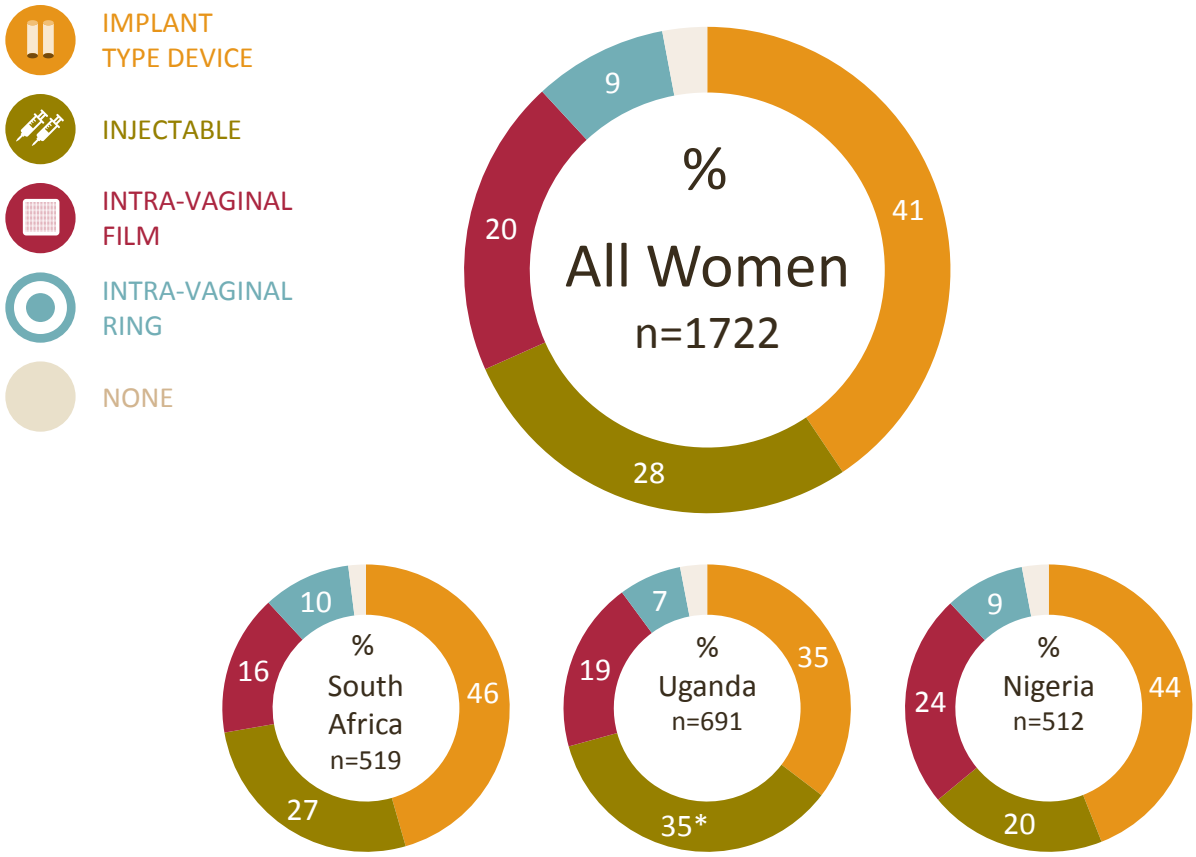
Despite high resonance for the MPT concept, no one MPT is fully accepted

MPT ACCEPTABILITY

After seeing all 4 MPT profiles

- There needs to be more than one MPT available to optimise coverage of women
- The Implant and Injection are most acceptable – they work for a broad range of women
- On the contrary, the Film is demanded by specific groups of women
- Whereas, the Ring is least acceptable – with very few women agreeing they would demand it should it become available

WHAT WOULD WOMEN USE IF ALL 4 MPTS WERE AVAILABLE TO THEM TODAY?



MPT form demand *if only one was available would women use it*

Uptake of each MPT increases, however less so for the Ring

MPT ACCEPTABILITY

After seeing all 4 MPT profiles/ yes or no

- The Implant and Injection remain the two most preferred MPTs
- For women in South Africa and Nigeria the film also gains strong usage
- Furthermore, the Film continues to be a strong option for women in Nigeria, more so than the Injection.
- Nearly half of women in Uganda would use the Ring if it were the only MPT product available to them. In spite of this, significantly fewer women would use the Ring compared to the other MPTs (in particular Nigeria)

WOULD WOMEN USE THE MPT IF IT WAS THE ONLY ONE AVAILABLE?

% YES	Total (n=1722)	
	75% +34%	*Large increases in demand from women in Uganda (+44%) then South Africa (+36%). Nigeria slight increase (+20%)*
	71% +43%	*Large increases in demand by women in South African (+50%) and Uganda (+46%) then Nigeria (+29%)*
	60% +40%	*Nearly half of Uganda and South African women express increase in demand (+43%, +48% respectively) Under a third increase demand in Nigeria (+28%)*
	36%* +27%	*Largest increase in Uganda (+41%), then South Africa (+25%) and barely any change in Nigeria (+11%)*

What these figures mean:

% women who would use the MPT if only one

% change increase from decision if all 4 MPTs were available

Drivers behind demand

The major drivers are: administration, duration, ease of use, size and appearance

Drivers for demand of MPTs

- The major drivers can achieve a greater impact on the likelihood to demand. Other factors like level of protection and side effects appear less influential when women comes to think of acceptability/ initial demand.
- However, the product must be backed by good protection and low level of side effects to ensure maintained use.

- ALL FACTORS ARE CRITICAL, but their prominence is different based on where they are in the decision making pathway, when it comes to acceptability and initial trial the most influential factors are different

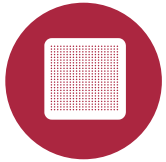
Reasons for choosing an MPT over another

n=
SA (237)
Uganda (244)
Nigeria (227)

1. Good duration: 50%, 66%, 50%
2. Trust health facilities: 33%
3. Easy to use: 32%,28%
4. Dual protection: 34%
5. Do not like inserting into vagina: 26%,37%
6. It is discrete: 28%

n=
SA (139)
Uganda (245)
Nigeria (101)

1. Good duration: 42%, 47%, 33%
2. Trust health facilities: 44%
3. Easy to use: 41%
4. Do not like inserting into vagina: 30%, 54%
5. Dual protection: 32%, 27%
6. Do not have to worry: 32%



n=
SA (82)
Uganda (133)
Nigeria (121)

1. Easy to use: 43%, 50%
2. Good duration: 29%
3. Do not like injections: 29%, 27%
4. Dual protection: 31%
5. It is discrete: 25%
6. I don't have sex so often so can use when I need it: 36%

n=
SA (52)
Uganda (48)
Nigeria (48)

1. Do not like injections: 31%, 44%
2. Duration: 31%, 31%
3. Ease of use: 25%, 40%
4. Dual protection: 29%
5. I don't like other products: 35%
6. I may want to get pregnant: 25%

Side Effects – what would you accept for MPT?

Women would not accept Migraines or Diarrhea. Women in Uganda found side effects more unacceptable – important to note for potential interrupted use

Contraceptive / Anti-Viral HIV drug side effects – acceptability

Women were told that these side effects would be mild and infrequent

(Red) Side effects (contraceptive)

(Blue) Side effects (Anti-viral HIV)

* = significantly more women in Uganda find these side effects more unacceptable than women from South Africa and Nigeria

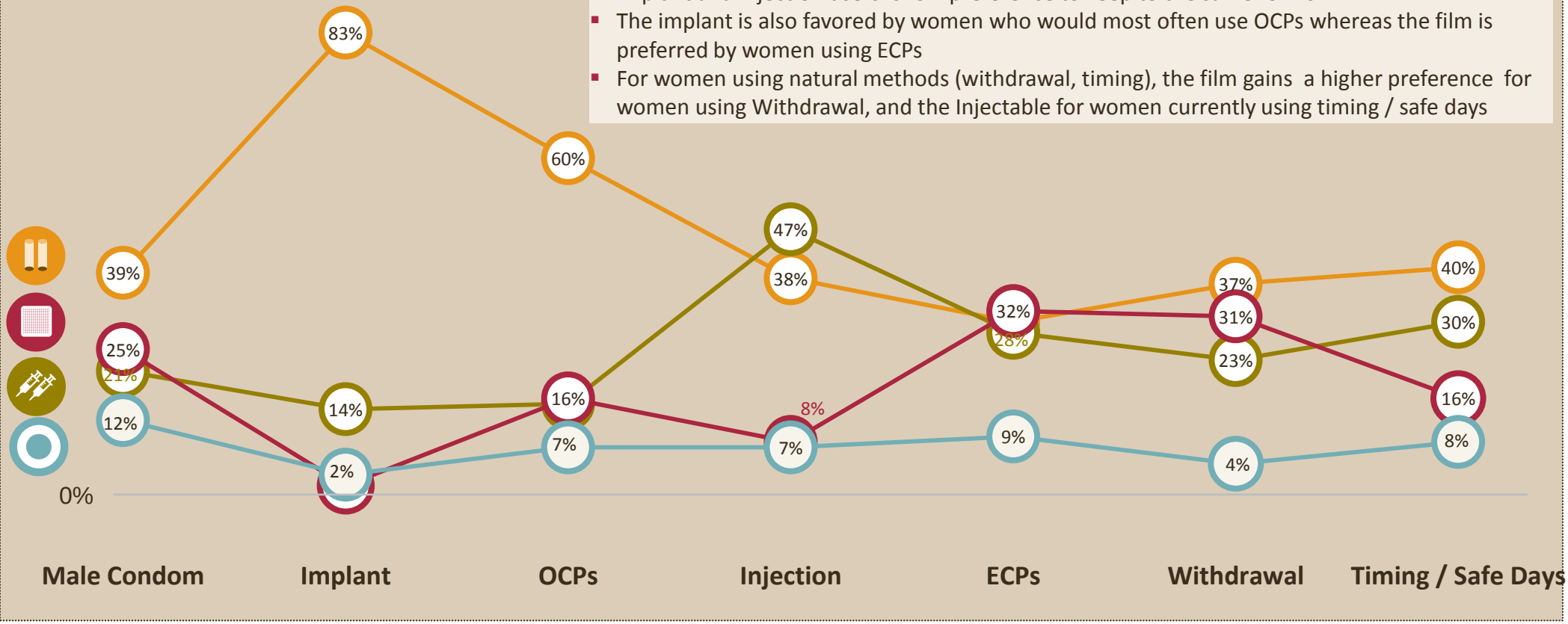
Note: wordles for side effects are proportionate to one another. i.e. migraines and diarrhea have the same overall %

Drivers behind demand – current contraceptive use

Women are more likely to choose an MPT based on either their experience (familiarity with the type of method) or their needs (on-demand protection or a longer term contraceptive)

Y axis – % choice to use an MPT if all available
X axis - All women, most often used contraceptive method

- Male condom users: preference towards the Film and the Ring, methods which also offer the on-demand use
- Implant and Injection users: show preference to keep to the same forms
- The implant is also favored by women who would most often use OCPs whereas the film is preferred by women using ECPs
- For women using natural methods (withdrawal, timing), the film gains a higher preference for women using Withdrawal, and the Injectable for women currently using timing / safe days



Drivers behind demand – who?

Both the Implant and the Injection resonating broadly across different women and life-stages whereas, the film presented an option to a more specific group of women

BROADER COVERAGE

n=
SA (237)
Uganda (244)
Nigeria (227)

n=
SA (139)
Uganda (245)
Nigeria (101)

- Women 26 yrs + frequent sexers
- Married women/ women living with partners
- Women who are mothers
- Women who are mothers who may not want more children
- Single women, mother, unmarried (SA)
- Dislike intra-vaginal methods
- Current users
- Students

SPECIFIC COVERAGE

n=
SA (82)
Uganda (133)
Nigeria (121)

- Young women (15-17yrs)
- Women in education
- Women who are not mothers
- Women in a relationship but not married or living with partner
- Infrequent sexers
- Urban women
- Women with casual partners (SA)

LIMITED COVERAGE

n=
SA (52)
Uganda (48)
Nigeria (48)

NOTE: SMALL NUMBER
More resonance with …

- Rural women
- Women who do not like injections

Important note: this is an acceptability study not a segmentation. We looked at those who stated preference for each MPT and whether certain 'profiles' of women stated greater preference than others. However, profiles listed under each MPT are not exclusively preferring those MPTs, other women within such profiles may have preferred other MPTs

IN THEIR OWN WORDS

Reactions from women on MPT forms …

INTRA-VAGINAL FILM

- "I do not like that you have to insert it twice and you have to keep watch of the time."18, Johannesburg
- "For sure this film does not look like it can prevent HIV and pregnancy." 30, Kampala
- "I like that I can do this at home." 17, Lagos

INTRA-VAGINAL RING

- "It looks like a bangle, it is hard and big, it should be smaller and softer more like a rubber band" 26, Gulu
- "I am not comfortable with all those times it has to be inserted, then removed...it is tedious" 16, Mbarara
- "This thing must go in and come out. Think about the female condom, people did not use it because they did not like it." 24, Cape Town

INJECTABLE

- "It would be useful to others since majority of us are using this method and with dual prevention it would save us." 17, Kampala
- "One injection even with larger needle is better. If there are 2 needles, you feel the first pain of the first needle then you must again feel the pain of the second needle. That makes you tense." 25, Cape Town

IMPLANT TYPE DEVICE

- "It has a long duration and you can remove it any time unlike the injection." 23, Kampala
- "It is good as you stay for 6 months and prevents you from HIV and you can stay 5 years not getting pregnant." 25, Cape Town

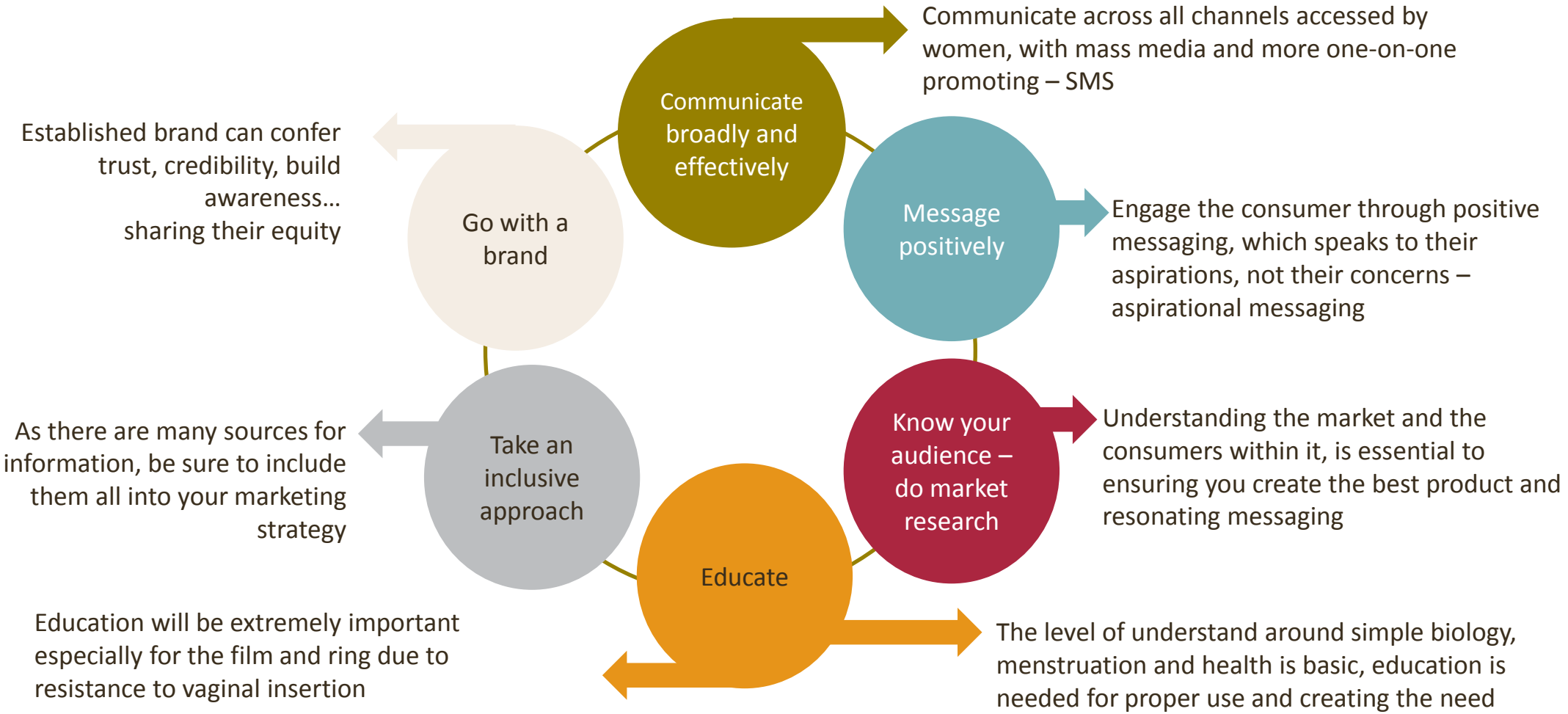
STRONG COMMERCIAL INTEREST IN THE FILM AND RING

However, from the perspective of an OTC focused sales approach MPTs are seen as a way for commercial companies to collaborate with

	Commercial Potential	Commercial Concerns	Approach	Key Maxims
INTRA-VAGINAL FILM 	• Great concept • Consumer friendly easy to use • Inexpensive • Really simple and practical • Discreet • Good for single ladies • Ideal for ladies who have infrequent sex • Offers women protection if partners refuse condoms • Complementary product portfolios	• Extensive educational campaign • Taboos and tampons resistance to vaginal insertion • Side effects • Maximum temperature and self- storage • Protection levels, Durex offers 99.99% to 100% protection • Application 12 hours before may forget 12 hours after • Many women receive free contraception which may limit commercial potential	• Go with a brand • Partner with a well-known and established company • Educational campaign • **Understand and reach your target market**	• Brand trust, Consumer Awareness, Market Knowledge, Sales, Education and Distribution
INTRA-VAGINAL RING 	• Duration of protection • OTC would widen appeal for commercialisation • Good for married women/long-term relationships/regular sex • Partnerships with soaps, hygiene products, pads	• Extensive educational campaign • Size, feel, comfort • Taboos and tampons = resistance to vaginal insertion • Hygiene concerns • Removal from vagina • Side effects • The man may feel it • More expensive than film • Many women receive free contraception which may limit commercial potential • Needs professional supervision • Counterfeit	• Go with a brand – however, clearly less OTC than the Film & need support from other organisations	• Brand potential • Empowering women • Hand wash • Sanitary Towels • Education programs

COMMERCIAL EXECS ADVISE YOU KNOW YOUR MARKET

As well as developing meaningful and aspirational messaging, education, going with a brand, backing from government and NGOs/Foundations for



IN CONCLUSION

We learnt so much … here are our key take-outs …

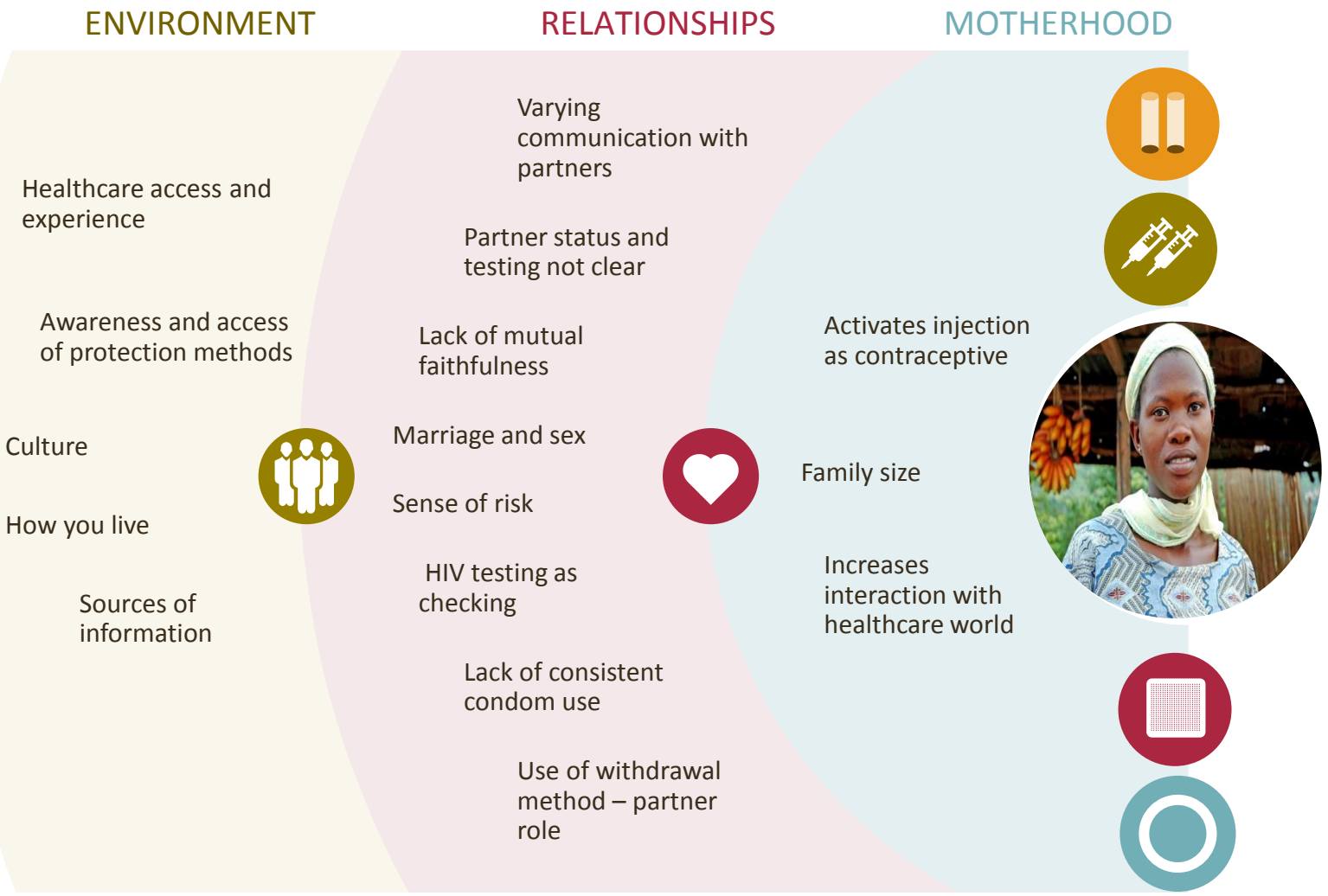
- Universal acceptance of the concept of an MPT
- Dual protection makes women feel empowered and safe
- No one MPT form is ideal
- Women's lifestyles are not uniform = options
- MPTs must be aligned with women's lifestyles and what they would demand
- The MPTs which fit best are:
    1. Implant
    2. Injection and
    3. Film – specific women/situation
- The Implant and Injection resonate more broadly, across situations and women's life stages – whether a mother or at school
- The Film has a clear place for women i.e. infrequent sexers, not married, not mothers, young women
- The Ring has less resonance and is demanded much less – there are barriers with regard to using the ring – it is neither familiar to what they are using now and not something they would imagine using
- There are strong commercial opportunities seen by company execs operating in the feminine hygiene arena, for the Film and the Ring – in particular with women in higher SEC/LSM

IN CONCLUSION

Putting women at the centre of MPT development

There are 11 rings, 11 gels, 2 pills, 2 films and 1 diaphragm in development (pre-clinical and clinical)

With important trial results next year, which will inform which MPTs could be introduced, whether it be in the form of a ring or as a gel, it is clear that a greater understanding of: women, the markets the MPT will be introduced in and its dynamic characteristics, and their respective healthcare systems is need to ensure optimisation of their impact.



"If you aren't going to fund the art of delivery, don't fund the science." **Mitchell Warren**

WHAT WE WOULD DO NEXT

Inside and outside of the MPT discourse

Whatever is going to be introduced, including the possibility of the ring, there needs to be more research done to support its introduction and optimise its success into each of the countries where it will be introduced. We can do this via putting women at the centre as well as the healthcare system, the community and the market dynamics

1. Put women at the centre of the MPT development continuum

Whatever is going to be introduced, including the possibility of the ring, there needs to be more research done to support its introduction and optimise its success into each of the countries where it will be introduced. We can do this via putting women at the centre as well as the healthcare system, the community and the market dynamics.

- A volumetric forecast on the MPT study results would properly discount acceptability and uptake measures
- Communication/messaging for product position research – for credible, resonance and relevance

1. Look at funding for MPT development - with the **strategic intent to maximize coverage of women and HIV infections averted**, a portfolio approach should be offered, answering to the different needs women have for different MPT forms – this most likely means offering a long-term HCP-administered option AND an on-demand self-administered option
2. Strategically, but aggressively support development of the Primary Healthcare system in Nigeria
   - Provide healthcare workers and nurses support to talk to women more about contraceptives and HIV across all countries (they have most of the discussions with women, see higher volume of women and give more time) – GPs have less time and are less proactive
   - Consider and assess consumer needs and perceptions to develop primary care system solutions that best meet needs and will require a minimum of demand generation efforts
3. Support development of stronger educational programmes for all women on: biology, menstrual cycle, contraceptiv
   - Utilizing important sources of information within each country, as well as introducing sources of information rel n
4. Support the development of the male condom – as most often used method for majority of countries, however in improvements could provide short-term benefits
5. Support HIV testing and increased community discourse on HIV – particularly in Nigeria

THANK YOU

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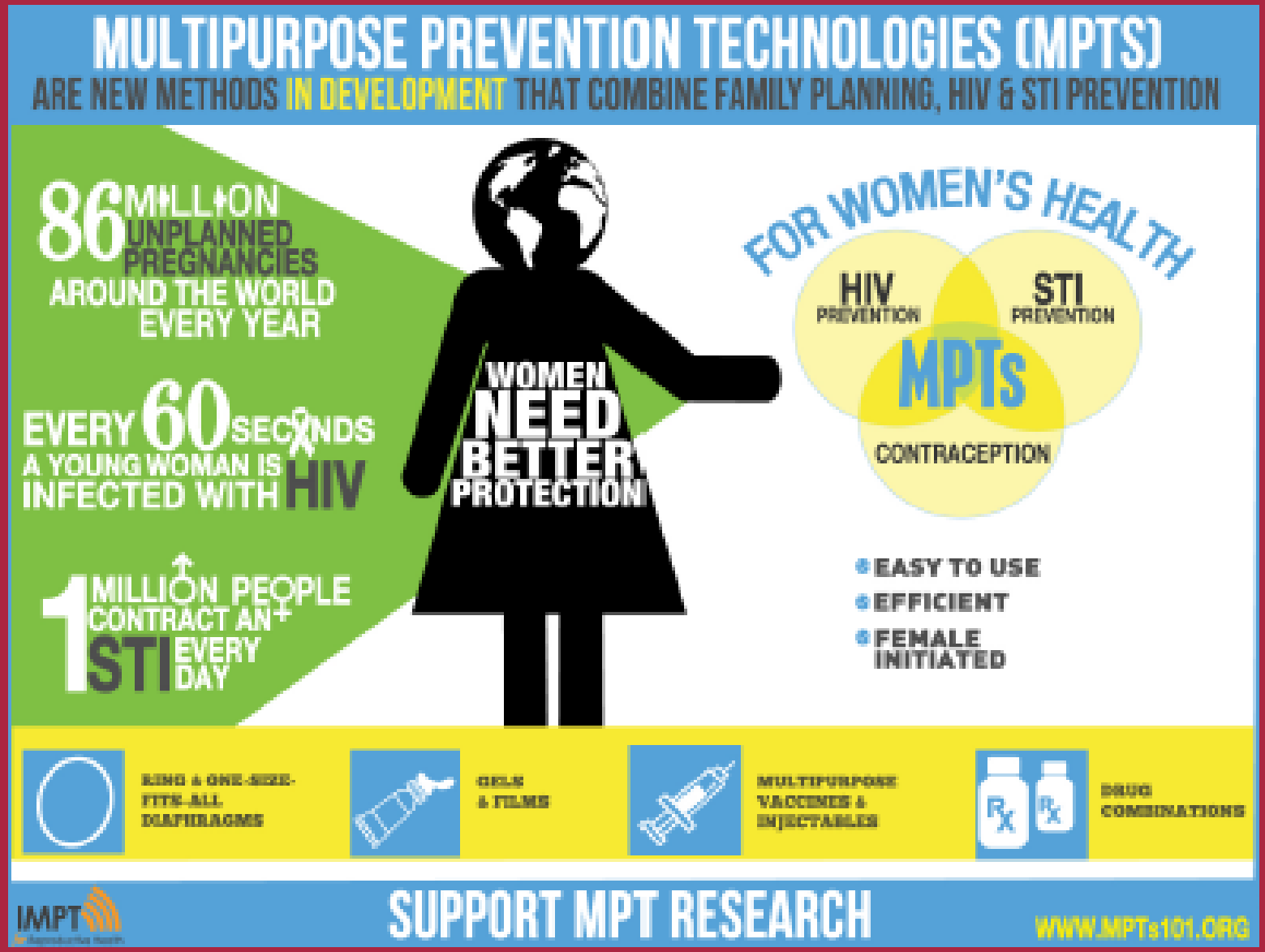
Discussion – Moderated by Bethany & Manju 15 mins



Sources: http://www.mpts101.org/infographic

Singh S, et al., *Unintended pregnancy: worldwide levels, trends, and outcomes*. Studies in Family Planning. 2010 Dec; 41(4):241-50.
UNAIDS. *Every minute, a young woman is newly infected with HIV*. Infographic. 2012.
WHO. Fact Sheet No 110. *Sexually transmitted infections (STIs)*. Updated November 2013.