Dual Prevention Pill Audience & Provider Insights Research and Marketing Plan

Phase 1 Research Findings

August 2022

CONTENTS

1. EXECUTIVE SUMMARY

In December 2021, AVAC commissioned M&C Saatchi World Services, together with REACH Insights and Humanly (hereafter: "the consortium"), to develop a marketing and demand generation strategy for potential users of a Dual Prevention Pill (DPP) for prevention of pregnancy and HIV acquisition in Kenya, South Africa and Zimbabwe. The consortium's approach to strategy development has been guided by the imperative to build the mental availability of the DPP brand among end users, by making it the first brand that they think of when thinking about contraception and HIV prevention (hereafter: "the category").

To generate the data and evidence necessary for strategy development, the consortium conducted robust qualitative research with women aged 20-40 and those likely to influence their decision-making around whether to use and adhere to the DPP in the future. The research design was guided by an ethnographic approach and drew on Human-Centred Design (HCD) principles and techniques to ensure the insights were grounded in an empathetic understanding of the lived realities of the target audience.

To ensure that this research did not duplicate existing knowledge, the design of the qualitative study was informed by a rapid desk review conducted by M&C Saatchi World Services. The desk review identified five key learning questions that needed to be investigated through primary research:

1. What are the **values, day-to-day lives and lifestyles** of the target audience, and how might these be leveraged to encourage adoption of the DPP?
2. What are the **opportunities and occasions** in people's lives where the DPP brand can drive relevance with the target audience?
3. Where are people having conversations about sexual and reproductive health (SRH), and which **channels** will cut through in these locations?
4. What is the end user's **network of influence** and how does this network influence decisions around sex, relationships and SRH?
5. Which **products** do current users access, purchase or use alongside OCP and/or PrEP, and what opportunities could these afford for DPP marketing?

This report highlights what the consortium learned from the desk review and presents the additional insights generated through primary research. A summary of findings is below.

WHO IS THE POTENTIAL DPP USER?

DESK REVIEW FINDINGS

Previous studies suggest that women who are already using OCP and/or PrEP are among the most likely to want to use the DPP. In all three markets, the number of OCP users is far greater than the number of PrEP users.

While there is very little data available on the demographic profile of PrEP users in the three countries, the demographic profile of OCP users varies somewhat by country. Compared to the average woman aged 20-40 living in each country:

- Kenyan OCP users tend to be older, wealthier and better educated, and are more likely to be married and to live in urban areas
- South African OCP users tend to be wealthier and are more likely to married or living with partners, university-educated and urban
- Zimbabwean OCP users tend be older and are more likely to be married

NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

Five potential DPP user personas were developed based on specific behavioural and emotional insights generated by the research (see Section 4 for a breakdown of personas across research participants). They include:

- **VICKY** – representing **new mothers**. Women like Vicky identify strongly as mothers and are motivated to use SRH products that will enable them to perform this role to the best of their ability, in a way that adheres to the social norms of motherhood.
- **LINDIWE** – representing women who want to **maintain their romantic relationships**. Women like Lindiwe care deeply about preserving their romantic relationships and make decisions about which SRH products to use based on whether they align with this goal. This can lead to decision-making that prioritises relationship goals over preserving SRH and increases the influence of male partners over female decision-making.
- **THANDIWE** – representing women who have **experienced or are at risk of unintended pregnancy**. Women like Thandiwe prioritise self-focussed values like education and career; however, romantic relationships also matter greatly to them. This tension, combined with challenges like low awareness of SRH options and lack of locus of control when it comes to use of prevention products, can lead to risky sexual behaviours.
- **ELSIE** – representing women who are **seeking enjoyment outside of marriage**. Women like Elsie prioritise the satisfaction of personal, self-focussed values (career, enjoyment), but still strive to perform a respectable, traditional role in certain relational and societal contexts.
- **FAITH** – representing women whose **male romantic partners are unfaithful**. Women like Faith care about protecting their health but find it difficult to negotiate safe sex with their partner due to concerns about how he may react. They are likely to prefer SRH products that offer discreet protection.

WHY ARE POTENTIAL DPP USERS ACCESSING (OR NOT ACCESSING) THE CATEGORY?

DESK REVIEW FINDINGS

There is a paucity of secondary data and evidence on the values, day-to-day lives and lifestyles of men and women in the target markets, and limited consideration of how these might be leveraged to support SRH product uptake. Much of the research to date has focussed on uncovering the range of tactical and functional considerations that influence decision-making, including affordability, availability, side effects, impacts on fertility, familiarity with the product and confidence in the product. There is a clear shift in communications on contraception and HIV prevention for women away from risk-based communications and towards those highlighting choice and empowerment.

NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

When deciding whether to use the DPP, end users are likely to juggle three competing sets of values: **self-focussed values** (career, enjoyment), **relationship-focussed** values (relationship goals, family values) and **community-focussed values** (religious / traditional values, social status). The pursuit of these values regularly impacts the day-to-day lives and lifestyles of end users. For example, many female participants across the three countries reported spending significant amounts of their weekly time: working, hustling and studying (*career goals*); having fun, socialising with friends, travelling, having sex and watching TV (*enjoyment*); with their partners (*relationship goals*); taking care of their families and doing household chores (*family values*); at Church and bible groups (*religious / traditional values*) and on grooming and doing things for their community (*social status*). Whereas male participants generally split their time between work and relaxation (for example, by hanging out with friends, playing sports and going to bars), **female participants' day-to-lives consisted predominantly of either working for income or taking care of domestic and family duties**, with less opportunity for indulging in leisure activities.

Brands that connect with a single value only may fail to reflect the complex lived realities and multiple goals of end users. There is an **opportunity to position the DPP as a product that makes it easier for women to juggle competing values** without having to make trade-offs for their SRH. For example, multiple participants suggested that the DPP could help women protect themselves from HIV with less risk to their romantic relationships or public image, by enabling them to disguise the DPP as an OCP. Some noted the DPP could enhance enjoyment of sex with partners by providing an alternative means for having HIV-protected sex other than condoms.

WHEN ARE POTENTIAL DPP USERS CONSIDERING THE CATEGORY?

DESK REVIEW FINDINGS

Secondary data provides some insight into when women may enter the category over a lifetime but limited insight into their day-to-day journeys. Trigger moments associated with women taking up contraception and HIV prevention include experiences of product failure, entry into an established risk group, discovery of a partner's

unprotected sexual behaviour, becoming pregnant, relationship status changes and changes in living situation. **Topics like 'birth control' and 'contraceptives' take up a very small share of people's attention in the three countries**. Audiences spend more time engaging with interests such as sports, business, beauty and politics.

NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

Most trigger moments to product entry reported were **associated with negative emotions**. Female participants also reported strong negative emotions when they learned about or experienced side effects. There is an **opportunity to position the DPP brand as helping women overcome moments of uncertainty and challenge**.

Insights generated demonstrate the **need to build DPP awareness and relevance among women far in advance of actual trigger moments**. Female participants, HCWs and cultural commentators all provided strong evidence that women form preconceptions and preferences for specific SRH products far in advance of actually needing one for themselves. There was no evidence in any of the user journeys that female participants change their minds about a particular product preference in advance of the trigger moment, nor in response to a recommendation by an HCW prior to the moment of uptake. Instead, **preferences for a given product tended only to change after the original moment of uptake**, for example in response to side effects.

Female participants mentioned multiple moments in their weekly routines and lives that early awareness-raising communications could leverage. These included: bridal parties / baby showers, watching TV / films with partner / friends, nights out, dating apps, entrepreneur / networking events, while listening to music, Church / bible groups, community dialogues / meetings, leisure time with family, playing / watching sports and places associated with grooming and beauty (e.g. hair salons).

WHERE ARE POTENTIAL DPP USERS ENGAGING WITH THE CATEGORY?

DESK REVIEW FINDINGS

The range of healthcare channel opportunities available to end users varies across the three countries, with variance in use of public vs. private sector service delivery channels. In Kenya, for example, the majority (58%) of OCP users aged 20-40 used a private channel (most often a pharmacy) to pick up their most recent prescription. By contrast, most OCP users in South Africa (78%) and Zimbabwe (70%) report public sector channels as their most recent source.

NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

Conversations about sex and SRH are happening in a variety of public, private, physical and online spaces. While such topics are not as taboo as they once were, they are still influenced by the legacy of hush-hush culture. This influence is

experienced more strongly for women, who have less licence than men to be seen speaking openly about these topics. Consequently, while women do talk about sex and SRH, these conversations tend to be restricted to private spaces, for example in the home, and are more likely to take place in female-only spaces.

Online spaces afford women in all three countries greater access to information about sex and SRH. Google is the go-to place for active information-seeking online, plus women consume information while browsing social media (for older audiences, mostly Facebook; for younger audiences, Instagram and, increasingly, TikTok). There was some evidence of women joining online groups, for example on Facebook and WhatsApp, for information about SRH issues. However, as with offline conversations, privacy, confidentiality and anonymity remain primary concerns within these groups, meaning women rarely shared personal or intimate details with other members.

In traditional healthcare settings, both male and female participants described feeling uncomfortable about being seen and overheard by others in their community. This may disincentivise accessing healthcare services, particularly those related to highly stigmatised conditions like HIV. Attitudes towards healthcare settings as places where women and men are happy to go and be seen by others also appears to vary by sex, location and country, with men, participants in rural communities and participants from South Africa identified as the most reluctant. These variations reflect multiple factors, including masculine gender norms which inhibit men from seeking help, the higher probability that a member of a close-knit community will be known and identified by others at the clinic and the perception of South African healthcare services as extremely inefficient and time consuming.

WITH WHOM DO POTENTIAL DPP USERS TALK ABOUT THE CATEGORY?

DESK REVIEW FINDINGS

The literature identified seven categories of influencer on women's SRH decisions: male partners / spouses, HCWs, friends / peers, parents, in-laws, new-born babies and romantic rivals. Of these, most attention has been paid to male partners and HCWs.

NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

Women tend to avoid talking about the specifics of their own sex life and SRH with all except their most trusted confidants. Among wider friendship circles, women prefer to talk about sex and SRH in general, non-specific terms. Within relationships, men and women may struggle talking openly about sex and SRH.

Male Romantic Partners

Many female participants already keep their use of SRH products secret from male partners and see the DPP as a means for doing this even more effectively. The

prevailing view is that the DPP has the potential to provoke male backlash by threatening masculine gender norms. Male partners were highly concerned about DPP efficacy and side effects affecting their or their partner's fertility and libido. At the same time, many male participants expressed their support for the DPP, with those who are younger, urban, highly educated and with a higher socio-economic background the most likely to express supportive attitudes towards DPP uptake.

Evidence of positive deviancy highlights the opportunity for targeted DPP communication to encourage explicit male partner involvement, for example by promoting male partner role models who demonstrate more progressive attitudes towards uptake of the DPP as a vehicle for social change.

HCWs

HCWs voiced generally positive reactions to the DPP. All HCWs interviewed believed that the DPP could provide positive benefits in their respective countries, and all said they would be happy to recommend the DPP to clients ages 20-40, assuming it proved to be effective, did not carry undue health risk and was not found to cause excessive side effects. They argued that the DPP would allow women to acquire prevention from HIV covertly, by presenting the pill as solely a contraceptive (or a contraceptive with added benefits attached), and as such alleviate some of the social and relationship pressures that currently limit women from, for example, taking up PrEP as a standalone product.

Counselling challenges specific to the DPP identified by HCWs included how to determine which component of the product may be causing which side effects, and what to do in cases where a client using the DPP wants to become pregnant.

HCWs recommended a **train-the-trainer, cascade approach to DPP information dissemination** within the healthcare system, led by relevant government ministries and starting with senior healthcare professionals (e.g., doctors, senior pharmacists).

Confidants

Many female participants described a trusted confidant who is their 'go-to' for advice and guidance about SRH – most often a best friend rather than a family member. Within user journeys, these figures played a critical role in influencing female participants' initial product preferences, plus provided trusted advice on navigating issues like side effects. **DPP demand generation may benefit from enlisting these figures as champions of the product**, and from adopting their tone and voice for communications.

Characteristics commonly associated with a confidant figure included: in-depth familiarity with the participant's background; ability to keep secrets; non-judgemental; similar life experiences, including around SRH and willingness to share personal experiences with the participant. Women in South Africa were less likely than participants in other countries to report having a close confidant, possibly because of the relatively higher importance placed on social status by female participants in South

Africa, which discourages the sharing of personal and intimate issues with others due to the risk of secrets getting out.

WHAT ARE THEY USING ALONGSIDE PRODUCTS IN THE CATEGORY?

DESK REVIEW FINDINGS

The review found no published data on the types of products that women in the three countries use or purchase alongside SRH products. Available data on OCP delivery across the three markets indicates that contraceptives are strongly associated with healthcare: they are packaged as medicines and sold alongside other medical products, rather than positioned within adjacent categories like beauty products. Other marketing campaigns have designed branding to help women use SRH products discreetly.

NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

Both PrEP and OCP are generally framed and perceived as a form of medicine. However**, storage and adherence behaviours highlight scope for the marketing and demand generation strategy to think beyond the confines of the medicine category**. Products were commonly stored alongside a mix of beauty products, indicating the potential for partnerships with lifestyle and beauty brands. Women also commonly decant pills into a container of their own choosing rather than leave them in the original packaging, suggesting that the design of DPP packaging may benefit from thinking about the end storage devices (bags, purses) rather than just the original box and container, which may end up being discarded by users early on.

In terms of reactions to DPP design prototypes, blister pack packaging was preferred to a PrEP bottle. Participants were generally happy with the look of the pills, although some called for it to look more like a food supplement. As much as possible, the DPP should be designed, packaged and branded to resemble a contraceptive rather than PrEP. Finally, packaging the DPP as OCP+ with the added benefit of HIV protection, rather than paying equal attention to OCP and PrEP, may allow women to present their use of the DPP as a means of contraception, and to dissociate the DPP from the stigma associated with HIV/PrEP. This may also leverage the fact that many female participants are more worried by pregnancy than they are about contracting HIV.

CONSIDERATIONS: DPP DEMAND GENERATION AND MARKETING STRATEGY

Drawing on the insights generated in this research, below are some considerations for the DPP Demand Generation and Marketing Strategy, which are presented in detail in Section 6 of the report. The considerations are sorted into five clusters:

1. **OVERALL POSITIONING OF CATEGORY / DPP BRAND**

Connect with different sides of women's identities: For women to want to take the DPP, it is not enough for them to believe in the health benefits. Women need to believe that the DPP aligns with their values, beliefs and identities, and that they can take the pill without damage to their social status or reputation.

Connect the DPP with relationship goals: Currently, OCP/PrEP are seen as products which can put people's relationships at risk. There is a role for communications to flip this perception, showing that those who take the DPP are doing so because they care about their partner and want to protect the relationship.

Connect the brand to people's aspirations and lifestyle goal: End users spend much more time thinking about personal aspirations than potential health risks. Connecting the DPP to these aspirations, for example by showing how it helps them to be ready for the negative shocks, may help the DPP gain a greater share of mind.

Leverage different triggers/need states for media targeting: most triggers to usage of OCP and PrEP related to negative experiences in people's lives, such as a partner's infidelity. This is likely to be the case for DPP, making these more negative triggers significant category entry points which can be targeted through media placement.

Use OCP as an entry point for the DPP rather than PrEP: Use of PrEP is surrounded by greater stigma and negative associations than OCP. Positioning the DPP as OCP+ with the added benefit of HIV prevention, with packaging branded to resemble a contraceptive rather than PrEP, may prove a more effective market entry point than giving both sides of the product equal weight in communications.

2. PRODUCT ATTRIBUTES, SERVICE DELIVERY AND DISTRIBUTION

Design packaging like products in the food supplement or beauty category: Drawing inspiration from adjacent categories like supplements and beauty can provide multiple benefits, including making it easier for users to take the DPP covertly and to improve the product's distinctiveness relative to other products on the market.

Equip HCWs to support women through the challenges of taking the DPP: communications need to educate HCWs about the benefits of the DPP and increase awareness and acceptance among them. HCWs also need to be equipped with messaging to support women to overcome mistrust of products due to fear of side effects or misinformation, as well as support them in adhering to the product where there is limited acceptance from their partner or family.

Scale up the DPP at preferred private distribution channels: it will be important to rapidly scale distribution at preferred points of access such as pharmacies, leveraging compelling point-of-sale communications in these spaces, as well as more informative communications about pill usage and side effects which women who access the DPP through private channels can take away with them.

3. INFORMATION / PROMOTIONAL CHANNELS

Create central points of access for trusted information, beyond the information provided by HCWs: Once women are actively seeking information about SRH products, they often gather information online and from close confidants, even before they seek medical advice from a nurse at the local clinic. It will be important to create places where people can easily access credible information about the DPP before visiting the clinic, for example, on a social media page or website.

Expand to channels that offer greater privacy for sharing information on sex and relationships: Anonymous online health groups were particularly popular in South Africa, as were conversations with hairdressers and manicurists in Kenya and Zimbabwe. Partnering with these channels could enable women to access accurate SRH information in settings where they feel comfortable, with people they trust. Channels and strategies for engagement on the DPP will be further explored in the co-creation phase.

Utilize information channels beyond the health sector to reach people in their daily lives: Women form opinions and preferences for specific SRH products far in advance of their first visit to the health clinic, with little evidence of female participants later changing their minds about a particular product preference. Therefore, it is critical that communications intervene before women are actively considering SRH options. This option will be guided by country legislation on promotion of health products.

4. INFLUENCER AND COMMUNITY ENGAGEMENT

Leverage trusted members of women's network as advocates for the brand: Across all three countries, women spoke of having one or two close confidants that they would go to for information and advice about SRH. These figures could act as advocates and champions for the brand, positioning them as trusted sister or aunty figures who can provide anonymous support and advice to end users.

Turn supportive male partners ("positive deviants") into champions: Male-targeted communications which position the DPP as consistent with their values and beliefs can drive acceptability of the product among male partners. These communications can also role model men who are more supportive of the product and include reassurance and myth-busters to counteract fears about the effect of the pill on male and female fertility and libido.

Shift perceptions about who is likely to take the DPP: To increase the social acceptability of the DPP, there is a need to counteract existing negative perceptions and build a new set of positive associations around those taking it. For example, communications could build associations of the DPP with women who are thinking of their children's futures or their own career, or who are health conscious or just savvy about protecting themselves from male partners' risky behaviours.

2. INTRODUCTION

This report presents the findings of qualitative research conducted by M&C Saatchi World Services, REACH Insights and Humanly from April through July 2022. It also summarises key findings from a rapid desk review conducted by M&C Saatchi World Services to inform the design of the primary research.

The research was commissioned by AVAC to fill knowledge gaps and enrich insights generated by previous research, including earlier HCD research in Zimbabwe and South Africa. The research focussed on Kenya, South Africa and Zimbabwe. In each of these countries, research was conducted with 13 cisgender women aged 20-40 (29 total), 2 male romantic partners (6 total), 8 HCWs (24 total) and 3 cultural commentators[1] (9 total). In each country, the sample was split across one urban and one rural location. The decision to focus on women ages 20-40 was based on evidence that this cohort has higher rates of OCP and oral PrEP uptake and effective use of oral PrEP, making them more likely to be early adopters compared to adolescent girls younger than 20 years.

The design of primary research was informed by a rapid desk review undertaken in February 2022, which confirmed and identified gaps in the existing knowledge base and informed a set of key learning questions summarised below:

1. What are the values, day-to-day lives and lifestyles of the target audience, and how might these be leveraged to encourage adoption of the DPP?
2. What are the opportunities and occasions in people's lives where the DPP brand can drive relevance with the target audience?
3. Where are people having conversations about SRH and which channels will cut through in these locations?
4. What is the target audience's network of influence and how does this network influence decisions around sex, relationships and SRH?
5. Which products do current users access, purchase or use alongside OCP and/or PrEP, and what opportunities could these afford for DPP marketing?

This report presents the insights generated in response to these questions. Section 4 presents five DPP user personas and associated journeys. Section 5 provides an overview of key insights that emerged from the research. Section 6 draws out the main implications of the research findings for DPP roll-out, presented as a set of evidence-based considerations to inform the DPP Demand Generation and Marketing Strategy.

[1] Defined as persons capable of providing insights into the trends, nuances and idiosyncrasies defining sex, relationships and SRH in their countries. See Annex 1 for more details.

3. METHODOLOGY

To generate the data and evidence necessary to answer the study's key learning questions, the research design incorporated qualitative research with multiple audience categories, employing a range of methods and techniques. This research was conducted in one urban and one rural location in all three countries. For further details on the research approach and methodology, see Annex 2.

TABLE 1: RESEARCH SAMPLE AND METHODS

Method	Participant Profile	No of participants per country	
		Urban Loc.	**Rural Loc.**
Immersion (2x sessions per participant)	Current OCP users	3	3
	Current PrEP users	2	2
	Unmet FP need	2	1
	Male romantic partners	1	1
	Total immersions	**8**	**7**
Friendship circle	Female immersion participant + friends	1 circle	1 circle
	Male romantic partner + friends	1 circle	1 circle
Key informant interview (Zoom or face-to-face)	Healthcare workers	4	4
	Cultural commentators	3	

TABLE 2: RESEARCH LOCATIONS

Country	Kenya	South Africa	Zimbabwe
Urban location	**Nairobi**	**Gauteng Region** – City of Johannesburg	**Harare**
Rural location	**Nyanza Province** – Rural locations around Kisumu	**Kwazulu-Natal Region** – uMgungundlovu, uMzinyathi, Uthukela and Ilembe Districts	**Matabeleland North Region** – Rural locations around Bubi

4. USER PERSONAS AND JOURNEYS

The research generated five DPP user personas and associated user journeys, all reflecting current users of OCP and/or PrEP. See Annex 3 for each journey plus further detail on how they were developed and how they will inform strategy development. Of note, personas will not be static for end users; a woman may transition between personas at different stages in her life course. Personas and journeys will be iterated on in the co-creation phase.

A NOTE ON DATA BARS USED IN THE PERSONAS

Each of the personas described below includes a set of data bars indicating their likelihood to accept the DPP and the importance of six values to that persona.[2] These personas, including the bars, are based solely on qualitative data, and as such are illustrative only. The purpose of the data bars is to indicate:

- which personas may be most likely to accept the DPP
- the relative importance of different values (and sets of values), and therefore the trade-offs that are most likely to inform a given persona's SRH decisions

[2] Empowerment goals and enjoyment (self-focussed values), relationships goals and family values (relationship-focussed values) and religious/traditional values and social status (community-focussed values). Each of these values is examined in-depth in Section 5.1.

4.1. VICKY'S PERSONA AND JOURNEY

PROFILE

- Product: OCP
- Married
- Mother
- Recently gave birth to first child
- Skews towards 20-30 age bracket

TRIGGER FOR CATEGORY ENTRY

- Started using OCP after giving birth to her first child
- Wants to space birth of subsequent children

STORY

Vicky has always aspired to start a family and views motherhood as core to her identity. She started using OCP after giving birth to her first child because she believes child-spacing will help her give her new-born the best opportunities in life. However, Vicky does not see HIV prevention as relevant to her. Vicky's husband was initially not supportive of her desire to start OCP due to misconceptions about side effects. After speaking with a nurse, Vicky was able to understand more about contraceptives and how child-spacing can improve the financial security of the family, and so help him to be a better provider.

INFLUENCERS

- Mother/sister & in-laws, e.g. seeing them take OCP
- HCP, e.g. advice during postnatal session
- Husband is hesitant for her to take OCP but won't use condom

TOUCHPOINTS

- Bridal parties
- Baby showers
- Antenatal/postnatal visits
- Family WhatsApp groups
- Mothers' groups

DRIVERS

- Financial security – reduce the financial burden of more children
- A positive future for her child – Delaying the birth of her next child helps her give current children the best opportunities in life
- Maintain marriage (status symbol)
- Public conformity to social norms, e.g. being a good wife/mother
- Desire to do things differently with her own children (as her mother didn't talk to her about sex)

BARRIERS

- Husband is putting pressure on her not to use OCP/PrEP – for him, multiple children is tied to his identity
- Fear of side effects, rumours about effect of OCP on mood swings, libido, and future fertility
- Doesn't see HIV prevention as relevant to her
- Religious stigma around OCP
- Need to hide OCP from partner & feels unable to talk to him about it

CONVERSION OPPORTUNITY

Likelihood to accept DPP

VALUES

SELF-FOCUSSED VALUES

Career goals

Enjoyment

RELATIONSHIP-FOCUSSED VALUES

Relationship goals

Family values

COMMUNITY-FOCUSSED VALUES

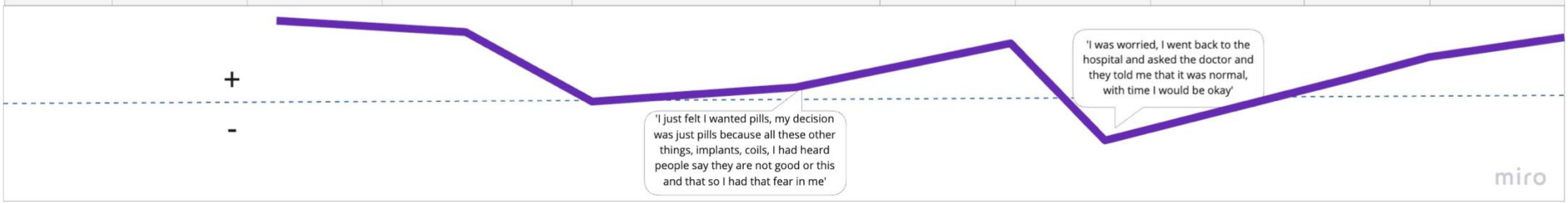
Religious / traditional values

Social status

Vicky has always aspired to start a family and views motherhood as a core to her identity. She started using OCP after giving birth to her first child because she believes child spacing will help her give her newborn the best opportunities in life. However, Vicky does not see HIV prevention as relevant to her. Vicky's husband was initially not supportive of her desire to start OCP, due to misconceptions about side effects. After speaking with a nurse, Vicky was able to understand more about contraceptives, and how child spacing can improve the financial security of the family, and so help him be a better provider.

'It is challenging at times but it is fun, it is awesome being a mum.'

Vicky	Trigger	Initial consideration/Active evaluation				Post-purchase experience		Switch/stop/continue		
Key Moments		Talk to someone	Seek information	Seek medical advice	Seek a contraceptive method	Start using a contraceptive		Continue using OCP	Stop using OCP	Start using OCP
Actions	Vicky gives birth to her first child and is advised that she should leave a gap before having her next child.	Vicky talks to her partner who agrees that delaying more children is a good idea, but he does not want to use condoms.	Vicky goes online to do research into different contraceptive methods because she doesn't know much about them, and wants to go to the clinic with some information. She looks up what methods are available and what the side effects are of different methods.	Vicky goes for her 6 week checkup with her baby and tells the nurse that she wants the pill. The nurse tells her about the side effects and about different types of contraception including the coil and the implant.	Vicky is encouraged by the nurse to consider the injection or the implant, however she tells the nurse that she wants the pill. She tells the nurse that if the pill works for her she will come back and get the implant.	Vicky starts taking the OCP right away - she has done her research and is confident in her choice.	Initially Vicky gets dizziness, nausea and loss of appetite when she starts taking the OCP. She is worried about this and goes back to the hospital.	After around a month, all of the more difficult side effects like nausea and dizziness have disappeared. Vicky now just has lighter, shorter periods so she continues taking the pills.	When Vicky and her partner want to have their next child, she stops taking OCP and quickly becomes pregnant.	Vicky starts taking OCP again after the birth of her second child. She does not want to switch to another method because she knows this works well for her.
People	Midwife	Partner	Self, Internet	Nurse		Partner	Doctor	Partner		
Places	Hospital	Home		Hospital		Home	Hospital	Home		
Emotions	Happy at the birth of her first child	Relieved that partner agrees	Confused by the different types of contraception available and the pros and cons of each	As she has done her research, Vicky feels comfortable with her decision and confident in stating that she would like the pill		Happy that she has been able to get the pill and relieved that she should now be protected from unintended pregnancy	Scared by the side effects caused by the pill	Relieved that the side effects have subsided and content that the product is working well for her	Happy that she is able to become pregnant with no problems after using contraception	Satisfied that she has a product that works for her, and confident that she won't get pregnant unless she makes the choice to do so



4.2. LINDIWE'S PERSONA AND JOURNEY

LINDIWE - MAINTAIN RELATIONSHIP

Johannesburg, South Africa

PROFILE

- Product: PrEP
- In a relationship but unmarried

DRIVERS

- Health security – does not want to contract HIV
- Enjoyment of sex
- Preservation of romantic relationship
- Social status that comes with being in a relationship
- Conformity with peer/social expectations

CONVERSION OPPORTUNITY

Likelihood to accept DPP

TRIGGER FOR CATEGORY ENTRY

- Started using PrEP after discovering that her partner was living with HIV
- Her partner had been keeping his status a secret, but she found his ARV bottle

STORY

Lindiwe started using PrEP after discovering that her partner was living with HIV and taking ARVs in secret. While Lindiwe was extremely angry at him for keeping this a secret and putting her at risk, she did not want to lose the security that the relationship provided or the social status that comes with having a male partner. She decided to start PrEP because she thinks it's a better alternative to condoms, keeps her safe without reducing sexual pleasure.

BARRIERS

- Feels under pressure from society to conform with the image of the perfect couple
- Worries about peoples' reaction if they discovered their partner was living with HIV
- Worries about being labelled HIV+
- Believes condoms are effective but that they reduce sexual pleasure
- Low awareness of other HIV prevention methods (e.g. PrEP)
- Doubts efficacy of PrEP and worries about side effects

VALUES

SELF-FOCUSSED VALUES

Career goals

Enjoyment

RELATIONSHIP-FOCUSSED VALUES

Relationship goals

Family values

COMMUNITY-FOCUSSED VALUES

Religious / traditional values

Social status

INFLUENCERS

- Partner
- Friendship circle
- Sister
- HIV testing clinic nurse

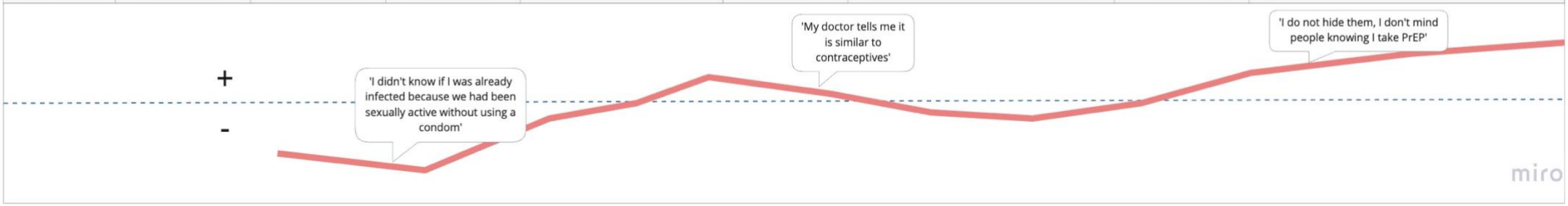
TOUCHPOINTS

- Google
- Social media (Facebook/Instagram/TikTok)
- WhatsApp / mobile phone
- HIV testing clinic
- Pharmacy

Lindiwe started using PrEP after discovering that her partner was living with HIV and taking ARVs in secret. While Lindiwe was extremely angry at him for keeping this a secret and putting her at risk, she did not want to lose the security that the relationship provided or the social status that comes with having a male partner. She decided to start PrEP because she thinks it's a better alternative to condoms, keeps her safe without reducing sexual pleasure

'If your husband has HIV, you love him and you do not want to part ways... I cried that day, I won't lie, because I had a fear that I had contracted it.'

Lindiwe	Trigger	Initial consideration/Active evaluation				Moment of product pick-up	Post-purchase experience		Switch/stop/continue	
Key Moments		Seek information	Talk to someone	Seek medical advice	Seek information	Decide to try an HIV prevention method	Start using an HIV prevention method	Side effects	Continue using an HIV prevention method	
Actions	Lindiwe's partner moves in with her. She is very happy and feels good about their relationship. She then finds that he has hidden medication in his belongings.	Lindiwe Googles the name of the pills that she found and finds out that they are ARVs. She confronts her partner and he tells her that he is HIV+.	Lindiwe calls her younger sister for advice. She tells her to go to the clinic to get checked and to find out what she can do to stay safe.	Lindiwe goes to the clinic and is tested for HIV. The results are negative, and the doctor tells her about PrEP and how it would be good to use in her situation. Lindiwe had not heard of PrEP and thought that condoms were the only option. She is relieved because she does not want to use condoms with her partner as they both think that it spoils sex.	Lindiwe doubts whether PrEP could be effective, and is very worried about side effects. The doctor reassures her that 'It is similar to contraceptives'	Having had her worries addressed by the doctor, Lindiwe decides to pick up the medication that day.	Having picked up the prescription that day, Lindiwe informs her partner and starts taking PrEP that day.	Lindiwe does not experience any side effects, and has regular blood tests to check for HIV, which reassures her that PrEP does work.	Lindiwe keeps her PrEP in her wardrobe and some in her bag, so that if she is not home at 8pm when she usually takes her PrEP she can take it whilst she is out and about. She takes her PrEP at the same time as her partner takes his ARV medication, so that they can remind each other.	Lindiwe continues taking PrEP, as well as having a rapid test every 3 months and a lab test every 6 months so that she is sure that she has not contracted HIV.
People	Self	Self, Internet, Partner	Sister	Nurse/doctor, Other clinic staff	Doctor	Doctor	Partner	Nurse	Partner	Nurse
Places	Home	Home	Home	Clinic		Clinic/Pharmacy	Home	Clinic	Home	Clinic
Emotions	Very angry that her partner kept this from her	Scared that she could already have contracted HIV from her partner	Hopeful after speaking to her sister	Relieved that there is a way to stay safe and continue to have an enjoyable sex life	Apprehensive that it could be too good to be true, it must either not work or cause lots of side effects	Anxious that it will cause side effects. The doctor has been reassuring, but reading about the possible side effects makes her worry again		Relieved that there are no side effects and that she is still negative	Hopeful that she can continue to have a good relationship and stay safe	



4.3. THANDIWE'S PERSONA AND JOURNEY

PROFILE

- Product: OCP
- Unmarried and not in a serious relationship
- Skews towards younger, urban audience, age 20-30

TRIGGER FOR CATEGORY ENTRY

- Started using OCP having an unintended child at a young age
- Had been having sex without protection, as her then-boyfriend didn't like using condoms and she didn't know about other options

STORY

As a younger woman, Thandiwe had always planned to complete her studies and start her career before having a child. However, maintaining her relationship was also important to her, as her boyfriend brought her social status and helped fund her lifestyle. Pressure from her boyfriend to stop using condoms led to unintended pregnancy at an early age, as she did not want to risk losing the relationship. Following the pregnancy, Thandiwe started using OCP, which she felt she had more control over.

INFLUENCERS

- Grandmother
- Aunty
- Midwife, doctor, chemist
- Male romantic partner
- Friends / peer group

TOUCHPOINTS

- Friends WhatsApp groups
- Night clubs, bars
- Dating apps
- TV shows
- Music (e.g. Gengatone)

DRIVERS

- Ambitions for her future, e.g. finishing her studies, career goals
- Taking pleasure in "the finer things": expensive dinners, fancy parties, a new phone
- Maintaining her physical appearance through grooming, beautiful clothes and jewellery
- The social status that comes with having a man who is well-groomed, successful and wealthy

BARRIERS

- Prioritises relationship and social status values over SRH risks
- Lack of familiarity with product options beyond condoms
- Unwillingness to access healthcare services, compounded by a negative interaction with a paternalistic HCW
- Doesn't want to be seen as promiscuous if family/community finds out she is taking PrEP
- Fear of side effects

CONVERSION OPPORTUNITY

Likelihood to accept DPP

VALUES

SELF-FOCUSSED VALUES

Career goals

Enjoyment

RELATIONSHIP-FOCUSSED VALUES

Relationship goals

Family values

COMMUNITY-FOCUSSED VALUES

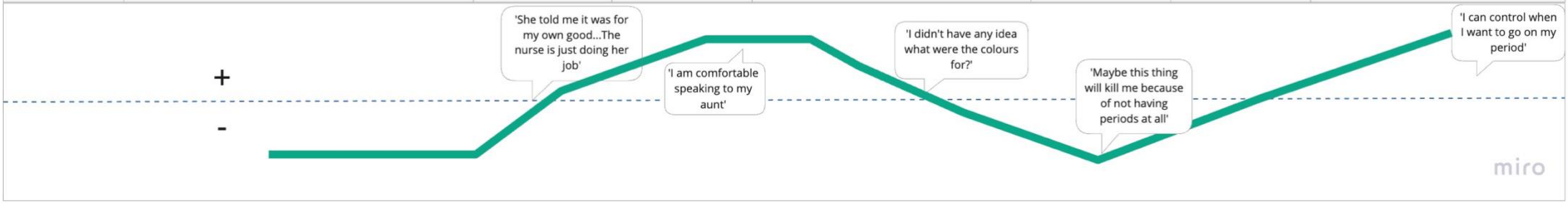
Religious / traditional values

Social status

Thandiwe had always planned to complete her studies and start her career before having a child. But maintaining her relationship was also important to her, as her boyfriend brought her social status and helped fund her lifestyle. Pressure from her boyfriend to stop using condoms led to unintended pregnancy at an early age as she did not want to risk losing the relationship. Following the pregnancy, Thandiwe started using OCP which she felt she had more control over.

'I don't know if I was ignorant or if I was not aware that I can go to the clinic and get any method to prevent me from getting pregnant. I'm not sure when I wasn't aware or I was not interested in knowing about that. But for me, it was said if I knew about abortion by the time I would have aborted the baby.'

Thandiwe	Initial consideration/Active evaluation		Moment of product pick-up	Switch/stop/ continue	Post-purchase experience		Switch/stop/continue		Continued use	
Key Moments	Talk to someone	Trigger	Start using a contraceptive	Switch contraceptive method	Seek a contraceptive	Start using a contraceptive	Seek a different OCP brand	Start an alternative OCP brand	Continue using OCP	
Actions	Thandiwe didn't want to have a baby young, but her boyfriend wouldn't use a condom and she didn't know about any other contraception. She talked to her grandma about having heavy periods and her grandma advised a traditional remedy of eating porridge from a metal plate.	Thandiwe became pregnant, which was unplanned. She did not know about abortions, and although she did not want to have the child she didn't know there was any other choice.	After giving birth, Thandiwe is given the contraceptive injection and told to come back in a few months when she can choose the contraceptive method she would like to use.	Thandiwe never goes back to the clinic. Instead, after 6 months she asks her aunt (who works with a doctor) what she should use. Her aunt advises her to try the contraceptive pill.	Thandiwe's aunt gives her 'Triphasil' to try.	Thandiwe takes Triphasil but finds it very confusing because the pills are lots of different colours and she doesn't understand why.	Thandiwe asks her aunt if there is a different type of pill she can try, because she finds all of the different colours confusing. Her aunt gives her white pills, which make her periods stop altogether.	Thandiwe asks her aunt if there are any other options, as she wants a pill that will make her periods regular. This time her aunt gives her Nordette.	Thandiwe continues taking Nordette, getting this free from her aunt or buying it from the chemist when she has to.	Nordette works well for Thandiwe. She has regular periods but if she wants to she can adjust when her period is.
People	Grandma	Self	Midwife, Doctor	Aunt , Doctor	Aunt		Aunt		Aunt, Pharmacist	
Places	Grandma's house	Home	Hospital	Home	Home		Home		Home, Pharmacy	
Emotions	Upset that she is young and pregnant		Fine, she perceives that the nurse is just doing her job and that is OK	Happy that she has found an alternative way to get contraception through someone that she trusts	Confused by all of the different coloured pills		Worried that her period vanishing will be bad for her	Happy that there are more options to try	Satisfied that she has a solution that works for her	



4.4. ELSIE'S PERSONA AND JOURNEY

PROFILE

- Product: PrEP and OCP
- Married
- Skews slightly older in 20-40 age bracket
- Has multiple children and not planning for more

TRIGGER FOR CATEGORY ENTRY

- Discovered her husband had a 'side-chick'
- Started using PrEP after beginning an affair with another man
- Started using OCP after her 'side-dude' advised her to seek protection

STORY

Elsie and her husband hold different values. He is older, traditional and wants a respectable wife who will take care of the household; she is ambitious, runs her own side hustle and wants to enjoy the finer things in life. Elsie has a "side-dude" who helps fund the lifestyle she wants by paying for expensive dinners and treating her with gifts. Elsie does not want to lose her reputation as a respectable woman, and goes to great lengths to keep their relationship a secret. Elsie started OCP/PrEP after the extramarital affair to prevent pregnancy or HIV.

INFLUENCERS

- Close friend / confidant
- Older sister
- Other girlfriends
- "Side-dude"
- Husband knows he puts her at risk but unwilling to discuss prevention

TOUCHPOINTS

- Dating apps
- Entrepreneur events
- Professional networks
- Party venues (clubs, bars)
- Pharmacy

DRIVERS

- Finding enjoyment outside marriage
- Pleasure, stress relief, companionship
- Business ambitions
- Desire to get even / find empowerment in secret ('tit for tat', 'draw draw')
- Sister/close friend encouraging her to find her own happiness
- Knows her partner is already cheating
- Financial benefits from side-dude, e.g. dinners, phone, rent (rural)

BARRIERS

- Pressure to hide PrEP (and her affair) from her husband and from others in her community
- Was told by Sengas / Aunties marriage is meant to be 'endured not enjoyed' and worries about keeping up the appearance of respectability
- Concerns about OCP/PrEP side effects
- Fear of stigma and being labelled promiscuous

CONVERSION OPPORTUNITY

Likelihood to accept DPP

VALUES

SELF-FOCUSSED VALUES

Career goals

Enjoyment

RELATIONSHIP-FOCUSSED VALUES

Relationship goals

Family values

COMMUNITY-FOCUSSED VALUES

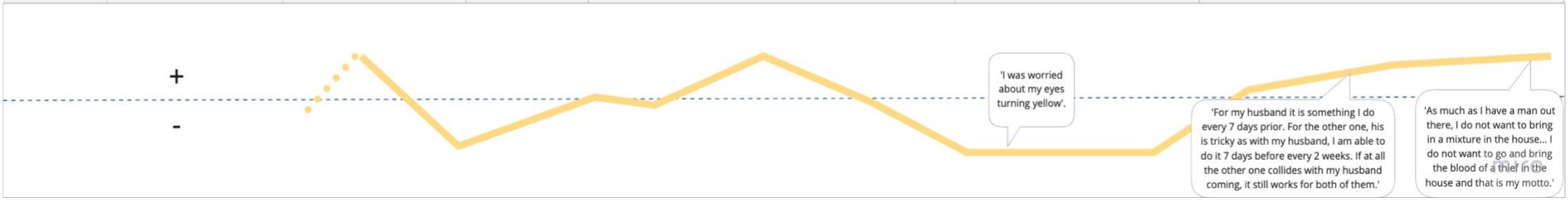
Religious / traditional values

Social status

Elsie and her husband hold very different values. He is older, traditional and wants a respectable wife who will take care of the household; she is ambitious, runs her own side hustle, and wants to spend time and money enjoying the finer things in life. Elsie has a side-dude who helps to fund the lifestyle she wants by paying for expensive dinners and treating her with gifts. However, Elsie also does not want to lose her reputation as a respectable woman, so goes to great lengths to keep their relationship a secret. Elsie started using PrEP after beginning the extramarital affair to prevent any chance of pregnancy or HIV infection.

'I used to fight, before I used to fight but later I learnt that this is this man's nature I need not fight. It wont change anything, fighting wont change anything yea.'

Elsie	Trigger	Initial consideration/Active evaluation		Moment of product pick-up			Post-purchase experience		Switch/stop/continue		
Key Moments		**Seek information**	**Seek medical advice**	**Seek a contraceptive and HIV prevention method**			**Start using a contraceptive and HIV prevention method**		**Continue using a contraceptive and HIV prevention method**		
Actions	Elsie and Jacob have unprotected sex and Jacob does not withdraw. Jacob tells Elsie that she needs to make sure she does not get pregnant. She has already taken the morning after pill but agrees to look into options. Jacob goes to his best friend, who encourages him to make sure Elsie does something to avoid pregnancy.	Elsie talks to a close friend, and mentions this is the 3rd time she has taken the morning after pill in a fortnight. Her friend encourages her to go to a clinic and find out about other options. She also suggests that Elsie asks about PrEP, since she is having sex with two men and they are also not exclusive, so she could be at risk of HIV.	Elsie goes to a clinic and asks to speak to a nurse. She explains her situation, and the nurse suggests that she has an HIV test before they decide what to do next.	Elsie's HIV test is negative and a doctor talks to her about PrEP and contraception. Elsie does not want the injection or depo because she has heard stories about both of those making you fat and causing long term problems, so she opts for the contraceptive pill.	The doctor gives Elsie PrEP and the OCP, and also explains the possible side effects.	Elsie is very anxious about starting to take PrEP. She has heard that it can turn your eyes yellow. Before she starts taking it she goes online and uses Google to find more information about PrEP and the side effects.	Elsie's husband is away for work when she gets the prescription, so she starts taking it right away to get used to it.	Elsie does not experience any side effects from PrEP or OCP.	Elsie continues to take PrEP and the OCP, however does so intermittently depending on when she is seeing her husband and when she is seeing Jacob.	Elsie takes PrEP for 7 days before seeing her husband or Jacob, and OCP for 7 days before seeing Jacob. With her husband she uses withdrawal to avoid pregnancy.	Elsie continues using PrEP and OCP, making sure to store them in different locations around the home to avoid them being found by her husband.
People	Elsie, Jacob	Elsie's best friend (who knows about PrEP)	Nurse	Doctor		Self, Internet	Self		Self, Husband, Jacob		
Places	Home	Elsie's friend's house	Clinic	Clinic		Home	Home		Home		
Emotions	Jacob is concerned about Elsie becoming pregnant. Elsie feels unsupported and under pressure.	Elsie is worried about the stigma she is going to experience	Elsie is apprehensive about the test results	Elsie is nervous about all the possible side effects, and has been worried by some of the things she has seen online			Elsie is concerned about side effects		Elsie is relieved that she is protected and has no side effects		



4.5. FAITH'S PERSONA AND JOURNEY

PROFILE

- Product: PrEP
- Skews towards married but also unmarried in serious relationship
- Relevant across all age brackets

DRIVERS

- Protection against her partner's infidelity
- Desire to prevent others finding out about her partner's infidelity
- Keep up the appearance of social respectability
- Talking to others in a similar position, e.g. close friend
- partner refuses to use condoms; she feels unable to bring up the conversation about prevention

CONVERSION OPPORTUNITY

Likelihood to accept DPP

TRIGGER FOR CATEGORY ENTRY

- Started using PrEP when she suspected her partner had been unfaithful

STORY

Faith started using PrEP because she suspects her husband is not faithful, as a way of keeping herself safe in secret, without the need for her partner's consent. Faith learned from others that cheating is normal behaviour for men. While she has confronted her husband about his infidelity, he refuses to discuss it with her and gets angry at the implication that he is not trustworthy. Because of this, Faith also does not see condoms as a practical solution: she and her husband have been together for a long time, and she knows he will interpret the demand for condom use as a sign that she does not trust him. She also does not want to leave him, because she wants to keep up appearances of respectability in her community.

BARRIERS

- Fear of partner's reaction if he discovers she is taking PrEP
- Lack of familiarity with the different methods to protect herself
- Worries partner will accuse her of not trusting him
- Few trusted confidants she can talk to about her situation
- Has to pretend she is unaware of partner's infidelity

VALUES

SELF-FOCUSSED VALUES

Career goals

Enjoyment

RELATIONSHIP-FOCUSSED VALUES

Relationship goals

Family values

COMMUNITY-FOCUSSED VALUES

Religious / traditional values

Social status

INFLUENCERS

- Close friend/confidant
- DREAMS community advocates
- Clinic nurse
- Ladies Health Online groups

TOUCHPOINTS

- TV dramas
- Community outreach programmes
- Local health clinic
- WhatsApp groups
- PrEP clubs (led by HCWs)

Faith started using PrEP because she suspects her husband is not faithful. She sees it as a way of keeping herself safe in secret, and without the need for her partner's consent. Faith has learned from others that cheating is normal behaviour for men. While she has confronted her husband about his infidelity, he refuses to discuss it with her and gets angry at the implication that he is not trustworthy. Because of this, Faith also does not see condoms as a practical solution: she and her husband have been together for a long time, and she knows he will interpret the demand for condom use as a sign that she does not trust him. She also does not want to leave him, because she wants to keep up appearances of respectability in her community.

'What made me want PrEP is the behaviour of my partner, you know people get lost and at times you are called by someone else's name or some messages get lost and end up in my phone. I realised that there were many of us and decided to protect myself.'

Faith	Trigger	Initial consideration/Active evaluation				Moment of product pick-up		Post-purchase experience		Switch/stop/continue	
Key Moments		Talk to someone	Seek information	Seek medical advice	Seek an HIV prevention method	Decide to try an HIV prevention method		Start using an HIV prevention method	Continue using an HIV prevention method		Continue using an HIV prevention method
Actions	Faith is suspicious that her husband might not be faithful. She then sees his phone and discovers he has been deleting Whatsapp messages which makes her even more worried. She is worried that her husband could be being unfaithful, which could also mean that he could be HIV+.	Faith is very close to her cousin and can talk to her about anything. She tells her cousin about her concerns about her husband. Her cousin asks if they use condoms, and Faith explains that her husband won't use them because he thinks that married people should trust each other and shouldn't use them. Her cousin tells her about a pill you can take that stops you from catching HIV, she doesn't know all the details but suggests that Faith finds out more about it.	Faith uses the internet to find out about the pills that her cousin has told her about, as she wants to know if they are safe. She reads about PEP and PrEP and thinks that PrEP would be best for her.	Faith goes to her local clinic to get an HIV test and ask about HIV protection. The nurse at the clinic is non-judgemental and informative. She tells Faith all about PrEP and why it is a good thing to take if you are worried you might be exposed to HIV.	Faith thinks that she would like to try PrEP. The nurse explains that she has to have an HIV test first and blood is taken to check that PrEP is suitable for her.	Faith has to wait for her blood test results. She is worried in case she is HIV+ and it is too late to use PrEP. She goes back to the clinic the following week and is told she does not have HIV and she can start taking PrEP.	Once Faith has the pills she is worried about how her body will react and the potential side effects that the nurse has told her about. When she opens the pill bottle and sees the size of the pills this also puts her off.	After a week she decides to try taking the pills.	Initially Faith experiences vaginal itching - this lasts for 2 days. It is unpleasant but the nurse explained that there would be side effects, so she knows that it will hopefully stop and she keeps taking the PrEP.	Faith also experiences some weight fluctuation for the first month of taking PrEP. She has not told her husband that she is taking PrEP and is concerned that he will notice and ask questions.	After a month of taking PrEP Faith no longer has serious side effects, so decides to continue taking it.	Faith keeps her PrEP hidden in a bag in her wardrobe when she is at home. She sets an alarm to take them at 9am every morning and takes them every day. If she is away from home she takes it with her and finds a way to take the tablet when she is out. If people ask she says she has a headache and it is a tablet for that.
People	Husband	Cousin	Self, Internet	Nurse		Self, Nurse	Self	Self			Self
Places	Home	Cousin's home	Home	Clinic		Home, Clinic	Home	Home			Home
Emotions	Stressed that her partner is being unfaithful, especially because she thinks this might mean that she is at risk of being exposed to HIV	Anxious because she does not know how she will protect herself when her husband won't use condoms	Nervous about PrEP and PEP because it is all new to her	Relieved that the nurse was so nice and confident that she now understands what would be best for her	Nervous about finding out whether she has already contracted HIV	Anxious about the potential side effects of PrEP and also about trying to take them because they are so big		Concerned that the side effects will continue and that her husband will become suspicious if her weight changes noticeably		Relieved that side effects have subsided, which can allow her to take PrEP discreetly and without trouble	

5. RESEARCH INSIGHTS

This section outlines key insights which formed the basis of, and are ultimately reflected by, the personas and journeys presented in the previous section. The section is structured to align with the five key learning questions guiding the primary research.

5.1. VALUES, DAY-TO-DAY LIVES AND LIFESTYLES

5.1.1 DESK REVIEW FINDINGS SUMMARY

The desk review revealed a paucity of data and evidence on the values, day-to-day lives and lifestyles of men and women in the target markets, and limited consideration of how these might be leveraged to support SRH product uptake. Instead, much of the research to date has focussed on uncovering the range of tactical and functional considerations that influence decision-making. These include affordability, availability, side effects, impacts on fertility, familiarity with the product and confidence in the product.[3] There is a clear trend in communications around contraceptive and HIV prevention for women away from risk-based communications and towards communications that highlight choice and empowerment.

5.1.2 NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

Both male and female participants are driven by complex, diverse and sometimes opposing sets of values

Conversations with male and female participants highlighted the breadth of values that are personally important to them. The analysis split these values into three categories: self-focussed, relationship-focussed and community-focussed.

The research indicates that female participants' decisions about SRH may be informed by values at one or several of these levels simultaneously, as they weigh the gains and risks of different options in terms of their various goals. Given the prevalence of communications already focussed on singular values such as choice and female empowerment, there may be an opportunity for highly distinctive communications that do more to reflect the interplay of different values. The three categories of values are summarised below, together with their implications for women's SRH decision-making.

1. **SELF-FOCUSSED VALUES**

[3] Unsurprisingly, all of these considerations were raised in conversations with research participants about the DPP specifically. The range of tactical and function barriers and drivers that may limit DPP adoption and adherence is also illustrated by the personas generated by this research.

Empowerment and enjoyment values could be leveraged to motivate DPP uptake

This category refers to values focussed on maximising the personal development, achievements, pleasure, excitement, wealth and prestige of the self. Among the most common self-centred values expressed by participants were (1) **empowerment values**, emphasising the achievement of professional success and the financial security that accompanies this success, and (2) **enjoyment values,** for example emphasising the importance of sexual pleasure, the consumption of "the finer things" in life and stimulation through travel and new experiences.

Both values were clearly manifest in descriptions of participants' day-to-day lives. Many participants, for example, spend a significant portion of their time working, hustling or (if younger) studying to maximise their chances of financial success. In terms of enjoyment, participants regularly engaged in various leisure activities, such as having sex, going to bars and restaurants, playing sports and travelling.

Female participants for whom empowerment values were highly important may be more likely to adopt prevention products like the DPP as a means of ensuring that HIV or pregnancy does not interrupt their goals. As Thandiwe's case illustrates, however, career goals may be balanced against other values (e.g. relationship goals) in ways that result in sexually risky behaviours.

Regarding enjoyment values, many participants (male and female) reported a tension between sexual pleasure and condom use, saying the latter reduced the former.

> *"Munhu wb ese anoda yeke (everyone loves unprotected sex) sister. I would really opt for that if it does not give me headaches."*
>
> - Female Immersion Participant, Zimbabwe

The relative importance of these values varies by age, socio-economic status and gender

Men were more likely than women to explicitly prioritise pleasure and enjoyment in descriptions of their personal values and day-to-day practices. Indeed, many men presented their lives as having a dual aspect: either they were working to provide for their families or, if not, they were spending time having fun. Men also prioritised sexual pleasure more commonly and explicitly than women, for example by describing their ideal partner in purely physical, sexual terms and attributing to her the importance of being able to relax and socialise.

More affluent participants (male and female) tended to spend more time and money on enjoying life, partaking in leisure activities such as travel and the consumption of "the finer things." This is likely due to the reduced demands on their time for maintaining financial security, due to a greater income.

There was more evidence of enjoyment values among women in South Africa than other markets, where they place a higher (at least a more explicit) cache on sexual pleasure and socialising than in the other markets. Participants also highlighted

their love of “the finer things.” The focus on these values was especially prominent among women living in Kwa-Zulu Natal.

> *“Not to be satisfied sexually can lead to a poor relationship. Romance to me is to buy a gift and to check on him every day, and make sure we spend a lot of time together and have a lot of sex.”*
>
> - Female Immersion Participant, South Africa

Among younger women, career values appear to be especially important during early adulthood, for example while at university. Older participants also sometimes referred back to their earlier days, when these values had been front-and-centre. As they got older, however, evidence suggests that female participants began to prioritise relationship goals and family values over self-focussed values such as career and personal achievement.

2. RELATIONSHIP-FOCUSSED VALUES

Two sets of value identified: relationship goals and family values

This category refers to values around the importance of preserving strong relationships with people close to you, for example partners, family and friends. These values were an extremely dominant theme, especially among female participants. For example, participants regularly represented themselves as friendly, helpful, kind, loving and good at communicating, and desired the same values in a partner. Women who were or aspired to become mothers (the vast majority) also communicated the huge importance they place on embodying maternal caregiving values.

In the context of SRH decisions specifically, evidence suggests that the relationships that female participants think about the most are their romantic relationships and their relationships with family. Consequently, the relationship-focussed values described for personas above focus on: (1) **relationship goals**, emphasising the importance of maintaining a stable, secure and loving relationship with one’s romantic partner, and (2) **family values**, emphasising the importance of enhancing one’s family security, caring for children and maintaining a positive self-image and relationship with siblings and, perhaps most especially, parents.

> *“I just hope that we continue to be together as a family, for my children to grow up healthy, disciplined and [that] I become a grandmother someday.”*
>
> - Female Immersion Participant, Kenya

Participants often judge relationship risks when making SRH decisions

Echoing previous studies, this research generated rich and varied evidence of female participants making decisions about their SRH based on judgements about the risk that different options pose to these relationships, often preferring options that pose the least risk – even at the expense of their health. Women reported hiding the existence of a romantic relationship from parents and grandparents, and keeping usage of a

specific product, for example PrEP or OCP, secret from a partner or family member. Some used a product only when absolutely required in order to avoid chances of detection. For example, a participant having an affair described only taking PrEP in the seven days before meeting her "side-man," rather than year-round. Some female participants said they agreed to not use a condom because a male partner said he did not want to, even in cases where the female participant knew the risks of this decision.

> *"If he agrees on condom, it would have been better as the condom would fight both HIV and pregnancy, but he refused the condom. According to him, condoms should be used by those who do not trust each other and those that go outside [of the relationship]."*
>
> - Female Immersion Participant, Kenya

Relationship goals often connected to other values, including personal and financial security, enjoyment of "the finer things" and social status

The research highlighted how women often depend on relationships with male partners to satisfy a range of other values that are important to them. As a result, women may be disinclined to talk about SRH issues with their partner or engage in practices that may upset him, for fear of losing the advantages he provides.

For example, it was very common for female participants to represent their ideal partner as their personal protector, financial provider and someone who will give them a house and access to "the finer things" in life. These descriptions underscore the ways women often rely on male partners to satisfy basic security needs, as well as to help them realise their ambitions for wealth and enjoyment. At times, participants and field researchers also highlighted the transactional nature of romantic relationships.

The connection between relationship goals and social status was particularly prominent in South Africa

In all three countries, research participants commonly identified being married[4] as a sign of social status and success as a woman. Data suggesting a link between a woman's social status and her relationship status was richest and most varied in South Africa. For example, female participants in South Africa were unique in emphasising the importance of finding a man who is well-dressed and well-groomed, and of keeping up these appearances themselves.

Local researchers connected this focus on appearances with the deep-rooted equation in many Black South African cultures of being able to attract and hold onto a male partner, on the one hand, and demonstrating competency as a woman on the other. As a result, they suggested women in South Africa care deeply about relationship

[4] 'Marriage' in this context may refer to both a legal marriage and a cultural marriage. For example, in South Africa, performance of the tradition of *lobola*, a form of dowry payment made by a man to his female partner's family, was accepted by some participants as a sign of marriage, regardless of the legal status of the union.

goals because their romantic relationships act as a sign to others that they are successful, competent women.

This cultural nuance may help explain why female participants in South Africa often displayed reluctance to share relationship problems with others outside of the relationship in their social network. For them, disclosing problems in the relationship to others risks creating the impression that the relationship is imperfect, therefore compromising the amount of social status it brings.

3. COMMUNITY-FOCUSSED VALUES

This category refers to values emphasising the importance of demonstrating compliance with socio-cultural norms and expectations. Across all three countries, the research generated evidence of both males and females aspiring to meet the expectations of what they believed men and women were supposed be.

For women and men, these expectations included **adherence to religious and traditional values**, for example by attending Church, regularly praying, demonstrating humility and modesty, remaining monogamous and faithful in marriage and respecting elders. **Demonstrating social status and respectability** was also important. For women, this was signified by being a high achiever, married with children and a happy, successful husband, being well-groomed, fashionable and monogamous (and certainly not promiscuous). For men, this was exemplified by becoming rich and successful and providing for one's family. Among male peers, men who could demonstrate success with women also acquired additional cache.

> *"I'm a provider, I'm the one who works. I'm the type to look after my family. My family is the most important to me."*
>
> - Male Immersion Participant, South Africa

As with self-centred values, there was variation in the relative importance of these values by geography and demographics. Adherence to religious and traditional values was especially important for Kenyan and Zimbabwean female participants, who underscored the importance of women dressing respectably and modestly and taking pains not to deviate from these expectations. Rural male and female participants cited a greater number of references to religious and traditional values. These included depictions of the Bible and God as a core part of the relationship, as well as references to values such as being prayerful, devout and humble.

> *"He has got to be God fearing, someone that I can find a home in, I have to feel secured around them, a dream chaser, focussed, but above all they have to love God."*
>
> - Female Immersion Participant, Zimbabwe

As noted above, in South Africa, female participants put a high premium on preserving their social status and respectability, highlighting the importance of grooming and appearance as a core responsibility of both men and women. They also exhibited

higher levels of distrust towards sharing intimate details about their sex lives and relationships even among friends, for fear of secrets escaping.

> *"There are some things you'd rather not share. Sometimes when you cry to your friends about relationship issues, they don't always have the best advice, and they will judge."*
>
> - Female Immersion Participant, South Africa

Participants frequently described the ways women's SRH decisions are influenced by community-focussed values

For example, women and men are far more concerned about the risk of unintended pregnancy – because of its visibility to others – compared to HIV, which is easier to conceal (particularly thanks to advances in medication) and therefore less of a threat to public image. Women also perform different identities depending on the social context, for example presenting a more respectable identity when with family and in-laws, and a more outgoing, pleasure-seeking identity among close friends. As part of this performance of respectability, women conceal usage of SRH products to prevent others from thinking that they may be promiscuous or living with HIV. They also keep secrets about their SRH and sex lives from all but extremely close and trusted friends. Given this tendency towards secrecy and discretion, women often reported a preference for SRH products that can be kept secret and used discreetly, to limit the chances of others finding out about them.

> *"I have a lady friend who uses [PrEP]. She discusses it with me openly, but you find that generally the society takes it that a lady who uses it and walks with these kits is a prostitute. Society thinks you are ready for sex anytime [and] that is why you are walking with the kits."*
>
> - Male Immersion Participant, Kenya

The DPP was immediately perceived as an innovation that could help women preserve relationships and public image without compromising sexual health goals

The DPP was widely viewed as offering women a means by which they could acquire protection from HIV that posed less risk to both their existing romantic relationship with a male partner and their public image in their community and society more generally. More specifically, the DPP was seen as offering a solution to relationship and social risks associated with condoms, on the one hand, and oral PrEP, on the other.

1. THE DPP VERSUS CONDOMS

In all three countries, the research found evidence of women foregoing use of condoms in response to a male romantic partner who complained that they either reduced sexual pleasure or were uncomfortable. Faced with this scenario, the consensus among research participants was that refusal by the woman to have

condomless sex risked the stability of the relationship, because it could signify that either she does not trust her partner or that she herself has something to hide.

Both female participants and HCWs viewed the DPP as offering a solution in this scenario, by allowing women to engage in sex without a condom with partners without compromising their personal protection from HIV. The DPP was seen as a means for women to avoid difficult conversations with male partners and to pursue goals such as maximising sexual pleasure and satisfaction within the relationship. It was also seen as especially compelling by and for women in sero-discordant relationships, as it would enable them to enjoy sex with their partners without fear of acquiring HIV.

> *"Men tend to be controlling. They don't want to use condoms but they also don't want their partners to protect themselves. Men always say women are on PrEP so they can prevent themselves from contracting HIV because they are unfaithful."*
>
> - Female Immersion Participant, Zimbabwe

2. THE DPP VERSUS ORAL PREP

Many female participants expressed reluctance to use PrEP because of, for example, the risk of a partner discovering that she did not trust him or of being mistakenly labelled as living with HIV, either by a partner or by members of the community at large. These fears were also common among active PrEP users, motivating them to do everything they could to keep their use of PrEP a secret.

Compounding these and other disincentives, both the primary and secondary research found evidence that women perceive the risk of HIV as lower than that of pregnancy. Consequently, **the incentive to take PrEP is often lower than the disincentives for doing so, whereas the reverse may be true for taking contraceptives**. This discrepancy is due to the perception of pregnancy as a more likely outcome of unprotected sex than HIV, by both men and women, such that women evaluate the negative consequences of unintended pregnancy as more severe than acquiring HIV (see Table 3).

TABLE 3: FACTORS INFLUENCING FEMALE PARTICIPANTS' SEVERITY ASSESSMENT OF CONSEQUENCES OF ACQUIRING HIV VS. UNINTENDED PREGNANCY

Unintended pregnancy	HIV
• Cannot be hidden = higher risk of loss of social status due to being perceived as promiscuous and irresponsible • Having a child is a lifelong commitment = higher risk to self-focussed goals • Male partners often perceive children as a lifelong financial commitment = high risk to relationship goals	• Advances in ARV medication mean HIV is now a manageable condition = lower risk to health • The strain and stress of taking ARVs once a day = no different from taking a PrEP pill once a day • HIV is not immediately visible to others = lower risk to relationship goals and social status

The **DPP was seen as offering a solution to the challenge of PrEP stigma by affording women who wanted to use PrEP the opportunity to disguise the pill as solely an oral contraceptive**. While the research uncovered some evidence of stigma associated with OCP, for example among younger, unmarried women who feared being labelled as sexually promiscuous, use of OCPs is both far more common and less socio-culturally proscribed than use of PrEP. Consequently, female participants, HCWs and cultural commentators expressed excitement toward the potential of the DPP to open opportunities for less secretive, but still discreet, means of acquiring HIV protection.

The DPP was also seen as having the potential to engage women with low HIV risk perception to take up HIV prevention, by playing to their increased risk perception of unintended pregnancy instead.

> *"It will get rid of the stigma as you may be taking it to prevent HIV but you will be free to tell someone that you are taking it to prevent pregnancy. You are killing two birds with the same stone."*
>
> - Female Immersion Participant, Kenya

5.2. OPPORTUNITIES AND OCCASIONS FOR DRIVING AWARENESS AND RELEVANCE

5.2.1 DESK REVIEW FINDINGS SUMMARY

The desk review provided some insight into when women may enter the category over a lifetime, but limited insight into their day-to-day journeys**.** It identified a wide range of trigger moments associated with women entering contraceptive and HIV prevention categories, many of which are reflected in the user journeys generated for this research.[5] An analysis of 'birth control' and 'contraceptives' searches online showed that these subjects take up a very small share of people's attention. Broader interests they spend more time engaging with include sports, business, beauty and politics.

5.2.2 NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

1. USER JOURNEY INSIGHTS

Most trigger moments to product entry are associated with negative emotions

Comparing the five archetypal user journeys presented in the previous section, all but one (Vicky, a new mother who had a planned pregnancy) begin with the female participant experiencing fear, pressure, stress and sadness.

Usage of PrEP, in particular, was associated with female participants responding to risks outside of their control, such as unfaithful male romantic partners. Almost all (11 of 13) female PrEP users consulted for this research started using PrEP after suspecting or discovering that their partner was unfaithful and 1 whose partner had kept their positive HIV status secret during the relationship (see Annex 4).

> *"I felt that since he started cheating, I have to protect myself."*
>
> - Female Immersion Participant, Kenya

Female participants report strong negative emotions when they learned about or experienced side effects

Side effects emerged as one of the biggest concerns for female participants of all ages, across all countries and in both urban and rural locations. This was clear from both participants' actual prevention journeys as well as from non-users' explanations of why they did not use contraceptives or HIV prevention products. They described hearing myths, rumours and misinformation about the risk of side effects from a variety of sources, including online, through friends, family and HCWs themselves.

[5] Trigger moments identified in the desk review included: experiences of product failure (e.g. burst condom), entry into an established risk group (e.g. sex worker, sero-discordant couple), discovery of a partner's unprotected or extramarital sexual behaviour, becoming pregnant, changes in relationship status and changes in living situation (e.g. leaving home for university).

> *"The only thing that troubles me with drugs is the side effects. We had a discussion coz like my two other sisters got married before me so we have to discuss with them. My elder sister told me she had used the hand one (implant) and it made her very thin so she discouraged me. My younger sister was using the injection one, Depo. I think she bled continuously and because of that, I also feared because I believe because we have the same genes it will manifest in the same way."*
>
> - Female Immersion Participant, Kenya

Concern about side effects was also a dominant theme of conversations about the DPP itself. While most female participants said they would be willing to try the DPP if offered, many also said they would need to understand more about potential side effects before arriving at a final decision. The side effects that appeared to most worry the greatest number of female participants included loss of fertility, lowered libido, irregular or severe menstruation, weight gain and severe pain and discomfort, such as headaches and nausea.

The most positive moments along user journeys include talking to someone, seeking medical advice and deciding she's found the right product for her

The emotions and feelings described by participants completing user journey exercises were often most positive when recalling speaking to a trusted friend, family member or HCW about what they should do to protect themselves. The importance of these types of people for women's SRH decision-making and practices are examined in greater detail in Section 5.4.

User journeys also demonstrated a general upward trend in female participants' emotional states, most prominent after a participant had an opportunity to experiment with a product and concluded that it would work for her. This decision was often made after side effects had subsided, signalling that the participant had found a product that would be feasible for her to take in the long-term.

> *"I started feeling comfortable after using PrEP for a year with me using it and going to get tested over and over again. That is when I concluded that my pills were working. I am now comfortable because I no longer have that fear."*
>
> - Female Immersion Participant, Zimbabwe

2. UNDERSTANDING WOMEN BEYOND THE SRH LENS

Build awareness and relevance among women far in advance of actual trigger moments

Female participants, HCWs and cultural commentators found women formed preconceptions and preferences for specific SRH products far in advance of actually needing one for themselves. For example, female participants described forming a

preference based on observing what close family members or friends were using, or because of what they had learned in school.

There was no evidence in any of the user journeys of female participants changing their minds about a particular product preference if it had been formed in advance of the trigger moment. There was also no evidence of them changing their mind in response to a recommendation by an HCW prior to the moment of uptake. Instead, **preferences for a given product tended only to change after the original moment of uptake**, for example in response to side effects. Female participants mentioned multiple moments in their weekly routines and lives that these early awareness-raising communications could leverage.

TABLE 4: NON-HEALTHCARE FOCUSSED TOUCHPOINTS FOR COMMUNICATING WITH END USERS ABOUT SRH AND THE DPP

Touchpoint	Quotation
Bridal parties / baby showers	*"One time I was invited to a bridal party… To my shock and surprise, the few women who were there had nothing good to say about marriage. I am looking at the bride and she was freaking out. I was like, 'No it is not supposed to be this.'"* - Cultural Commentator, Kenya
Watching TV/films with partner/friends	*"We have dinner and watch TV. Myself and my partner have a chat until it's time for bed."* - Female Immersion Participant, South Africa
Nights out	*"I often go out with them when they go for drinks, so we often chat when we're out and give each other life tips."* - Female Immersion Participant, South Africa
Playing the dating game (e.g. via Dating apps)	*"On Tinder, there is Target so you will have to set terms of people you want to interact with… For me, I want to interact with people within 40km of my radius."* - Male Immersion Participant, Kenya
Entrepreneur / networking events	*"There are some 3 friends of mine that we are very free with and we go for chamas (all-women savings / investment groups) together. You find that we are in a room and I just take it (PrEP)."* - Female Immersion Participant, Kenya
Listening to music (e.g. Gengetone)	*"I just listen to music. I can even go outside and visit the friends that are around me, we sit and listen to music and talk. I listen to Hip-Hop, RnB, Afrovibes and even local music. As long as it has the vibes, I will flow with it."* - Female Immersion Participant, Kenya
Church / bible groups	*"In church, you put it in a way because what God put together no man should put asunder. We sit like women and talk about HIV, the things that are happening and people are not to be stigmatised."* - Female Immersion Participant, Kenya

Community dialogues / meetings	*"We have information dissemination sessions about sexual health and relationships that are usually held targeting women every Wednesday in our area facilitated by our local VHW. It is a safe space and women find it easy to participate as there will be no men around."* - Female Immersion Participant, Zimbabwe
Leisure time with the family / with children	*"I will definitely be there for her. I know I lost a mother at a very young age, I know what that means I know what I am missing even right now so I will try to cover up by applying this to my daughter. To be a platform to talk out."* - Female Immersion Participant, Kenya
Playing / watching sports	*"I have done a couple of programs with PZAT that have helped me to also talk to my peers and friends on health issues. We started a netball team targeted young women with the aim of using sport to help share information."* - Female Immersion Participant, Zimbabwe
Places associated with grooming and beauty (e.g. at hair salons)	*"Even in scenarios where women face challenges from their partners at home, salon conversations always created a safe space for advice and hacks of going around some of the problems being encountered."* - Cultural Commentator, Zimbabwe

5.3. PLACES AND SPACES WHERE PEOPLE HAVE CONVERSATIONS ABOUT SRH

5.3.1 DESK REVIEW FINDINGS SUMMARY

The range of healthcare channel opportunities available in each country includes a mix of public, private and non-governmental / community channels. There is significant variance in use of public vs. private sector service delivery channels across the three countries. The review presented a breakdown of the TV, radio and print media patterns of women aged 20-40 in each market, as well as each country's levels of digital and social media penetration. See Annex 5 for further details.

5.3.2 NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

As Table 5 illustrates, the primary research helped identify a broader range of spaces within which women and men have SRH-related conversations, outside of healthcare settings. These categories are defined in terms of the type of space / place (physical, online and healthcare setting) and whether a space / place is public or private. Subsequent insights describe the kinds of conversations associated with these places and spaces, together with cultural norms and practices that influence what can and cannot be said in each context.

Conversations about sex and SRH are not as taboo as they once were, but are still influenced by the legacy of hush-hush culture around sex and SRH

In all three countries, there in an increasing openness and public discussion around issues of sex, relationships and SRH. This was seen as particularly true for younger people, who are perceived as more open and willing to talk about sex and sexuality.

However, participants acknowledged (through words and deeds) that the legacy of the older generation's more socially conservative attitudes to sex and sexuality remains strong. As such, while all three countries indicated a trend towards increased conversations about sex, many participants reported still going to great lengths to not be seen or (over)heard publicly talking about sex and sexuality.

> *"I do not like it when I have to air my things in the open. At some point, if a secret is between two people, then it is not a secret anymore."*
>
> - Female Immersion Participant, Kenya

TABLE 5: 5 PLACE / SPACE CATEGORIES FOR CONVERSATIONS ABOUT SRH

PHYSICAL	ONLINE	HEALTHCARE

PUBLIC	• Bars / clubs / beer halls • Restaurants / Shisa nyama (South Africa) • Shopping malls • Fast food restaurants • Hair / beauty salons (women only) • Sports games (men only) • Community meetings / dialogues (rural only)	• Facebook groups • Public WhatsApp groups	• Waiting rooms • Pharmacies / chemists / queues for product pick-up • PrEP clubs
PRIVATE	• Participant's home • Close friend / confidant's home • Driving in the car • Public spaces considered busy enough or loud enough to prevent overhearing (e.g. a loud club or a private table)	• Google • WhatsApp conversations • Personal Instagram / Facebook pages	• Assessment rooms

Conversations about the specifics of a personal relationship or SRH issue tend to be restricted to private spaces. This preference was particularly pronounced when participants wanted to talk about the specifics of their relationship, sex life or SRH. These are subjects that participants said they would only talk about in select contexts, including:

- Most commonly, private, 1-1 settings with trusted confidants, typically in the home or in the privacy of a clinical assessment room
- Sometimes, through private, 1-1 messages sent via WhatsApp and Facebook – although as these could be read by others, this method was sometimes seen as unsuitable for really intimate conversations
- In public settings where the person is confident they cannot be overheard, such as a loud club or private table at a restaurant
- Healthcare settings in which the participant is confident what they say will remain confidential and in which they can remain anonymous

Conversations about sex, relationships and SRH outside of these spaces tend to be much more general and superficial. These conversations include, for example, the sexual escapades and attractiveness of celebrities, gossip and rumours about what others have been doing, rating the attractiveness of mutual connections and (among men primarily) superficial bragging about one's sexual prowess and conquests.

Men are perceived as having greater licence than women to talk about sex in public spaces, due to divergent gender norms associated with sex and sexuality. In all three countries, it was generally expected and accepted that men are highly sexually charged. For women, however, that same association carries connotations of immorality and a lack of respectability.

"For men it is easy for us to talk about sex without being labelled instead if you are shy or don't participate much in these conversations other men laugh at you and start questioning your sexuality."

- Male Immersion Participant, Zimbabwe

Open conversations about sex, relationships and SRH are more common when speaking to a member of the same sex

Participants indicated that women are far more likely to be open with other women about sex, just as men were more likely to be open with other men. This has an impact on the spaces in which men and women engage in conversation about sex.

Women-only spaces identified in the research included hair and beauty salons, shopping trips to the mall with girlfriends and doing household and community chores together, for example washing clothes. There was some evidence of women joining online groups, for example on Facebook and WhatsApp, for information about SRH issues. Membership of such groups was mentioned by women in all three countries, albeit only by a small minority. Within such groups, considerations of confidentiality and anonymity remain paramount, with women reporting that they would not volunteer personal information or issues if they thought there was a risk of it being linked to them by people they knew.

These groups may be particularly important in cases of women who feel like they have no one in their immediate social network they can talk to about SRH and relationship issues, and who are unwilling to access healthcare services. The findings of this research indicate that women in South Africa may be the most likely to satisfy both these criteria (see insight below for further details).

Attitudes towards healthcare settings as places where women and men are happy to go and be seen by others vary by sex, location and country

In the context of healthcare settings specifically, participants described discomfort about being seen and overheard seeking support for SRH issues. Spaces and places identified as particularly risky included, for example, waiting rooms, pharmacies and chemists on busy streets and in the queue to pick up SRH products and medication. Both men and women preferred to avoid being seen or heard in these locations for fear of being associated with stigma due to, for example, HIV.

Research participants in South Africa reported the greatest reservations about visiting healthcare settings due to both concerns about being physically seen at a healthcare clinic and because of the amount of effort associated moving through the South African healthcare system. This effort is associated with multiple factors, including:

- For clients who want to visit a hospital, for example, it is often necessary to visit a clinic first, obtain a referral and then travel to the hospital.
- Each of these steps can take a long time: during user journeys, several South African participants complained of long queues at service delivery points.

- As many clinics do not operate 24/7 and may be open only during working hours, patients are likely to be forced to choose between earning income or spending time and money to access healthcare services. In a no-work, no-pay society with high poverty rates like South Africa, this often leads to men and women (especially men) putting off seeking medical advice until the problem becomes so severe it cannot be ignored.

The research also produced evidence that women in rural settings are particularly unlikely to want to be seen in healthcare settings associated with SRH. In Kenya, for example, regular usage of emergency contraception appeared much more common in Nairobi than in Kisumu. Local researchers attributed this, in part, to the greater risk of a woman being recognised if she lives in a rural versus an urban environment. Due to the greater size and ethnic diversity of communities living in urban environments like Nairobi, women who visit the pharmacy are less likely to be personally identifiable or associated with a particular tribe.

> *"Most people have a fear of the clinic, so only seek clinic services when they are very sick and will not come just to get information or for the health talks. Men are even worse - they avoid the clinic at all costs. Young women are also fearful as they know that the nurses are a part of the community and are afraid that if they ask for contraception the news will reach their parents."*
>
> - Female Immersion Participant, Zimbabwe

In Kenya, most OCP users transition to the pharmacy for product pick-up. In South Africa and Zimbabwe, most stick with public healthcare service channels

The user journeys generated through primary research indicate that all current users of OCP and PrEP picked up their product for the first time from the clinic that they visited to seek medical advice. After that, secondary data suggests that women in Kenya transition towards using the pharmacy, with a majority of OCP users (58%) reporting the pharmacy as the place they collected their product. Women in South Africa and Zimbabwe, by contrast, appear more likely to return to public service delivery channels, such as hospitals and clinics (see Annex 5 for further details).

5.4. WOMEN'S NETWORK OF INFLUENCE

5.4.1 DESK REVIEW FINDINGS SUMMARY

The desk review identified seven categories of influencer on women's decisions about whether to use (and continue using) prevention products like OCP, PrEP and the DPP. These include male partners / spouses, HCWs, friends / peers, parents, in-laws, new-born babies and romantic rivals, for example other wives in cases of polygamy. Of these, by far the greatest amount of attention in the literature is paid to the influence of male partners and healthcare providers.

Male Romantic Partners

For many young women, maintaining romantic relationships takes precedence over health risks like HIV prevention. This can limit usage because there are various ways romantic partners can discourage women from using products, for example, by becoming suspicious that usage of a product is a sign of a woman's distrust or infidelity, and through the threat of intimate partner violence (IPV)). The percentage of women who report make contraception decisions either jointly with or mainly at the behest of their partners varies across the three countries.[6]

At the same time, male awareness and consent about their female partner's use of SRH products can increase adherence. There is also evidence of the positive impact that training in partner communication and conflict resolution can have on tackling gender norms.

HCWs

It is imperative to ensure that HCWs receive proper training to deliver SRH products, for example on how the product works, modes of administration and how to counsel on side effects. Challenges associated with HCWs include paternalistic attitudes towards and negative character judgements about women who they perceive as behaving either immorally or lacking the necessary competency to use an SRH product, all of which may demotivate them from recommending a product to a client. There is also evidence of HCWs feeling overwhelmed by the manifold demands on their time and attention, as well as calls for interventions to effectively address cases of reproductive coercion[7] and IPV in response to female usage of SRH products.

Other influencer categories

Support from parents and other family members can help encourage SRH product uptake and adherence, but disclosure by women to family can be difficult due to fear of stigma and backlash. There is evidence of reproductive coercion by in-laws, most commonly mothers-in-law. Peer and friend support acts as a key mechanism by which

[6] Women aged 20-40 in South Africa are the most likely to report sole decision-making responsibility for contraception decisions (44%), followed by women in Kenya (30%) and finally Zimbabwe (only 18%).
[7] Reproductive coercion is a collection of behaviours that interfere with a woman's decision-making related to reproductive health.

women navigate challenges, including reproductive coercion and doubts and concerns about SRH products. Fear of romantic rivals can motivate women to take decisions that are risky to their sexual health. There is evidence of women choosing to use both contraceptives and PrEP after giving birth out of a desire to protect and enhance the welfare of their child.

5.4.2 NEW CONTRIBUTIONS FROM PRIMARY RESEARCH – MALE ROMANTIC PARTNERS

Within relationships, men and women may struggle to talk and be open about sex and SRH

Multiple female participants described difficulties raising SRH topics with their partners. Moreover, many female participants keep their use of SRH products secret from male partners, and see the DPP as a means for doing this even more effectively.

The practice of keeping SRH product use a secret from male partners was observed among female participants using both OCP and PrEP and was especially widespread among PrEP users. The practice suggests that some potential users of the DPP may prefer not to involve their male partner in their decision to use the product. Alternatively, some users might prefer to present the DPP purely as a contraceptive by concealing its HIV prevention properties.

There is a strong belief in the need for explicit male partner involvement in demand generation for the DPP

Research with HCWs and cultural commentators produced a consensus view that men needed to be proactively targeted to support the DPP. This was seen as necessary to limit the risk of product stigmatisation among male participants, which would result in greater barriers to uptake and adherence among women longer term. It was also presented as a positive step towards reversing socio-cultural gender norms equating SRH as solely the woman's responsibility.

While female participants spoke less about involving male partners in generating demand for the DPP, several did call for the need to make SRH a shared responsibility (or indeed primarily a male responsibility) rather than a female-only responsibility.

The prevailing view is that the DPP has the potential provoke male backlash by threatening masculine gender norms

Male participants, HCWs and cultural commentators all perceived the DPP as an innovation that could be interpreted as one that dismantles traditional patriarchal power structures. By removing the risk that a woman may become pregnant or acquire HIV, the DPP would, some argued, enable women to "act like men" and be sexually adventurous with minimal risk of consequences to herself. This in turn was expected to fuel fear and paranoia among male partners that their wives and girlfriends might be using the DPP to be unfaithful to them.

> *"They are likely to be affected more than the females on this issue. In as much as this pill in the future might be rolled out, I think plans should be in place on how the male counterparts will react to it once they realize that their female counterparts can move without fear and sample as many men when they are with them."*
>
> - HCW, Kenya

Many male participants expressed their support for the DPP, with caveats

While the prevailing view was that men would not be in favour of their own partners using the DPP, male romantic partners expressed generally supportive attitudes towards the DPP, saying that it was an innovation that would help address endemic issues of unintended pregnancy and HIV in their countries and communities.

Some male participants also said that they would accept their own partners using the DPP. In a number of these cases, they caveated their support by saying that they wanted to be consulted as part of the roll-out of the DPP. This may reflect a desire to remain in control of SRH conversations, aligning with masculine gender norms of authority and leadership (see Table 6, below, for further detail).

Like their female counterparts, even male participants who said they would be supportive of the DPP caveated this by saying they wanted to see proof of the product's efficacy and they would not support use of a product which caused significant side effects (either for them or their female partner). The side effects that most concerned male participants were connected to fertility and sexual pleasure, including reduction in their own or their partner's fertility or sexual libido.

> *"They feel that they do not want to add weight because of PrEP, Because of the family planning, others say that the boyfriends tell them that when they take the pills, it lowers the libido and so they become dry…"*
>
> - HCW, Kenya

The data suggests several ways of interpreting the discrepancy between the prevailing view and what male participants reported themselves

1. **Masculine identity norms are context-dependent**

Masculine gender norms are defined as "qualities of maleness that develop as a result of socialization rather than biological disposition."[8] Men's social status often depends on their ability to create a masculine identity that fits with these norms.[9] The qualities that matter most to the performance of this masculine identity are, moreover, often context-dependent. In other words, what it means to be a man may change depending

[8] Boles JK, Hoeveler DL. Gender. *Historical dictionary of feminism*. Lanham: Scarecrow Press; 2004. p. 146.
[9] Sileo K, Fielding-Miller, R, Dworkin, S, Fleming, Paul. "What role do masculine norms play in men's HIV testing in Sub-Saharan Africa? A Scoping Review". AIDS Behav, Aug 2018; 22 (8): 2468-2479.

on where and with whom a man is at a given point in time. Table 6 illustrates the masculine identity norms evidenced within the four different contexts in this research.

TABLE 6: MASCULINE GENDER NORMS: WHAT IT MEANS TO BE A MAN IN DIFFERENT CONTEXTS

CONTEXT	WHAT IT MEANS TO BE A MAN
In the community	• Leader • Morally upstanding • Professionally and financially successful • Helpful and generous • Makes the community a better place
Among male friends	• Fun-loving, relaxed, sociable • Confident and successful in picking up women • Able to provide practical advice based on experience (e.g. career or relationship advice)
With my wife / mother of my children	• Fertile (able to reproduce, provide children) • Financial provider • Protector • Advisor • Head decision-maker • Her motivator/role model (morally upstanding, ambitious, successful) • Open and honest, emotionally sensitive
With my "side-chick" / one-night stand	• Fun-loving, relaxed, sociable • Virile • Sexually adventurous • Lavish, generous

This variance helps explain discrepancies between the prevailing view of men's reaction to the DPP and male participants' reported personal views because it underscores how a man might react differently to the DPP depending on the salient context. For example, the same man might:

- Support the DPP as an intervention that benefits the community at large
- Present as relaxed about the DPP among male friends, to avoid being seen as stuffy and socially conservative
- Reject his wife's decision to take the DPP because it undermines his status as protector and provider, for example because he interprets her decision as sign that she does not trust him to keep her safe or because she is unfaithful
- Accept (and even encourage) a "side-chick" or one-night stand to take the DPP because it means they can be sexually adventurous and spontaneous without having to use a condom

2. The content and relative dominance of masculine gender norms varies by factors including age, education, socio-economic status and location type

The research indicates that male participants who are **young, urban, highly educated** and have a **higher socio-economic background** may be most likely to be supportive of their female partners using SRH products and potentially the DPP.

Male participants belonging to higher socio-economic backgrounds expressed more progressive views around ensuring their female partner's independence. Urban male participants placed less emphasis on traditional and religious values in their relationships. In Zimbabwe, male participants put the most emphasis on presenting as a leader within their communities and contributing to the good of the country.

> *"I do not know the last person you were with and you do not know the last person I was with. As I always say, fear me. You do not know where I was last and with whom. So, because one thing might lead to another and we have disagreed on using condoms, what will happen? I said health comes first."*
>
> - Male Immersion Participant, Kenya

> *"I'm aware if my girlfriend has another partner or not. We communicate and agree on when to meet and the terms of our relationship."*
>
> - Male Immersion Participant, South Africa

3. **Within every community and society, there are certain individuals and groups who deviate from social norms and practices**

Finally, it may be the case that some of the male participants recruited for this research are positive deviants with respect to the dominant social norms and practices of their communities. As such, these participants may be outliers compared to the male community at large, suggesting that most men are more likely to reject than support their female partners to use the DPP.

Even so, evidence of positive deviancy highlights an opportunity for the DPP to identify and promote the minority of men who do support DPP uptake and adherence as role models for driving social change and acceptance of the DPP within their communities.

5.4.3 NEW CONTRIBUTIONS FROM PRIMARY RESEARCH – HCWS

User journeys reiterated both the importance and the limits of HCW influence for facilitating SRH product uptake and adherence

As all of the journeys presented in Section 4 illustrate, for both PrEP and OCP, the first moment of product uptake was almost always at a clinic and benefited from the input of HCWs. Seeking medical advice was often associated by female participants with an uptick in their emotional state, as women came away from the interaction believing that they had acquired information that would help them protect themselves and also received guidance on how to cope with issues like side effects.

However, as has already been noted above, the research also unearthed numerous instances in which participants had already formed preferences for a particular product in advance of coming to a clinic. These preferences were shaped by influences including what others in a woman's social network use and say about different products, as well as hearsay and myths circulating online and at the community level.

Crucially, the research produced no evidence of women changing these pre-formed preferences in response to HCW advice alone. Instead, preferences changed only after a chosen product had been tried and found to be unsuitable – for example, because of side effects.

HCWs were generally very positive about the potential for impact of the DPP

HCWs indicated a consensus view that the DPP is an exciting innovation with the potential to both decrease rates of unintended pregnancy and HIV acquisition and mitigate some of the challenges currently limiting the effective delivery of SRH services in different countries. The main benefits HCWs associated with the DPP are below.

1. **Increasing likelihood of adherence relative to standalone products**

The first and among the most common benefits associated with the DPP by HCWs was improved adherence. By reducing the pill burden for women taking both contraceptives and PrEP, HCWs suggested the DPP would reduce the chance that their clients would miss a daily dose of one or the other pill regimen, thereby improving rates of protection against both unintended pregnancy and HIV acquisition.

> *"When we were talking about HIV, we realized that a majority of our clients were not adhering well because there were multiple pills. We even did a paper, it is yet to be published, but it shows that combined pills are actually helping with viral suppression. For sure, if you had one pill combined to take care of pregnancy and HIV prevention, my guess is it would be as good as two steps forward or more."*
>
> - HCW, Kenya

2. **Improving PrEP uptake and adherence specifically**

Some HCWs framed the ultimate benefit of the DPP primarily in terms of combatting HIV. By combining PrEP with a contraceptive, they argued, the DPP would allow women to acquire prevention from HIV covertly, by presenting the pill as solely a contraceptive (or a contraceptive with added benefits attached). Consequently, HCWs expected that the DPP would alleviate some of the social and relationship pressures that currently limit women from, for example, taking up PrEP as a standalone product.

3. **Removing disincentives for clients to access SRH healthcare services**

Some HCWs believed that the DPP could reduce disincentives for clients to access SRH healthcare services more broadly. They felt the DPP could reduce the time and financial costs associated with multiple clinic/chemist visits, for example by making it possible to acquire dual protection through a single clinic visit, reducing the time spent

by women queuing to collect medication and reducing the cost of dual protection (assuming the client currently pays for OCP and/or PrEP, and that the cost of the DPP is less than the combined price of the OCP and PrEP separately).

Some HCWs saw potential for the DPP to alleviate the social risk of being seen at an HIV clinic or in a PrEP collection line-up – for example, by making it possible for clients to acquire HIV prevention through a visit to a family planning clinic offering the DPP.

> *"If this pill was combined for this person, it will be so easy for this person. Maybe the chances of someone taking PrEP and just feeling there is a pill but they can skip OCP, at the end of the day, this person can get pregnant. But if this person is using one pill, it means the success will be better. Then the society perception; if they are taking one pill at the same time, for those who feel they want to hide because they are taking PrEP, it will be easier because they only have one pill to take and so 'no one should know what I am taking.'"*
>
> - HCW, Kenya

4. Increasing the efficiency of SRH healthcare service delivery

Through a combination of the benefits described above, HCWs suggested that the DPP could improve the efficiency of SRH healthcare delivery in their countries by:

- Reducing rates of unintended pregnancy and HIV among women, thereby reducing the expenditure of time, money and resources on these issues
- Integrating the delivery of protection against unintended pregnancy and HIV, paving the way for a range of product types to ensure women have options:
    - Long-acting implants or injectables (systemic) products
    - Long-acting and on-demand topical (vaginal) products
    - MPTs that protect against HIV plus other infectious diseases and/or pregnancy
- Making it simpler for healthcare workers to confirm whether a client has dual protection, by checking adherence to one regimen rather than two

HCWs indicated a need for additional support to navigate challenges

HCWs will need comprehensive information on the range of possible side effects caused by the DPP, how likely they are to occur and how severe they can become to assuage fears and support clients cope with them. They requested guidance on whether it is possible to attribute side effects to the different components of the DPP.

HCWs asked for information on what to do when a client using the DPP wants to stop using a contraceptive but stay protected from HIV, a question also raised by female participants.

Many HCWs consulted for this research echoed concerns voiced elsewhere about the negative effect that unsupportive partners, family members and communities may have on women's uptake of and adherence to the DPP.

"Majority will tell you that 'I don't want him to think that I don't trust him,' and you already don't trust him because first you have taken that initiative that you don't want him to think that you don't trust him. Second, 'I know for sure that he is [with] someone else, I just want to take precaution for the sake of my children'... You will see that these women will tell you that 'for sure I do not want to bring more problems in my home, I already have enough.'"

- HCW, Kenya

Providing HCWs with guidance on how to address these issues will be key to facilitating effective roll-out of the DPP. This guidance could incorporate recommendations for counselling all parties on the differences between ARVs, PrEP and the DPP and advise clients on whether and how to take the DPP discreetly and covertly, where necessary.

Moreover, guidance could indicate how to provide unsupportive members of clients' social networks (e.g. male romantic partners) with tailored information on the benefits of the DPP, address their concerns on side effects and advise them on how to support adherence. Lastly, it could help identify warning signs of women who may be subject to reproductive coercion, for example from partners, family members and in-laws.

Doctors, chemists and pharmacists called for in-depth specialised information on the pharmaceutical properties of the DPP

While HCWs at all levels expressed an interest in being able to talk about the medical properties of the DPP, doctors, chemists and pharmacists expressed the most interest in seeing as much detail as possible. This included requests for the data produced in DPP bioequivalence studies.

"My issue is the compliance component of everything, and then potentially exposing people to developing resistance to our first line ARV regimen. So what is the possibility of forming some form of resistance to the drug?"

- HCW, South Africa

HCWs recommended a whole-of-healthcare system approach to introducing the DPP, as well as a cascade model for information dissemination

In Zimbabwe, for example, HCWs suggested that the whole healthcare value chain had to be considered for capacity-building around the DPP. They recommended that the Ministry of Health play a leading role in promoting this product to build confidence among HCWs. They suggested that senior doctors and pharmacists be educated on the product, its pharmaceutical properties, how to administer it to clients and how to engage potential clients as they seek to recommend it, and for senior practitioners to develop training materials to cascade knowledge down to junior practitioners, nurses, assistant nurses and finally to community HCWs and volunteers.

In South Africa, HCWs felt it would be important to cultivate ambassadors within communities themselves, by targeting prominent influencers and decision-makers, educating them on the product and then tasking them with disseminating the relevant information in the most effective, locally sensitised ways.

> *"We could target prominent people who are living with them in their community, target them to tell them it going to help by doing this and this and all, and maybe information can slowly pass and then educate them."*
>
> - HCW, South Africa

5.4.4 NEW CONTRIBUTIONS FROM PRIMARY RESEARCH – CONFIDANTS

Many female participants described a trusted confidant who is their 'go-to' for advice and guidance about SRH

These confidants were exclusively female, and were commonly described as having an in-depth familiarity with the participant's background, for example due to being childhood and otherwise longstanding friends. They were able to keep secrets; by contrast, female participants regularly relegated friends and family deemed unable to keep a secret to the outer, least trusted circles of their social network maps. Confidants were also non-judgemental and had similar life experiences, including around SRH, such as an unfaithful partner or keeping an affair secret. Moreover, the role of confidant often went both ways, with each woman confiding in, sharing experiences with and advising the other. This was seen as a sign of trust and may provide an additional layer of security as each woman possesses the secrets of the other.

> *"She is a very good friend, she is not a gossip as such. I have other friends who I cannot share with and if they find me with men, I will tell them the men are my brother and uncle."*
>
> - Female Immersion Participant, Kenya

> *"I told you I consult Emily because she was the first person to get infection. She was the first person to tell me that she has been infected and she is HIV positive."*
>
> - Female Immersion Participant, Kenya

In most cases, female participants' 'go-to' person was a best friend. While it was sometimes a cousin or a sister, or perhaps an older trusted female advisor like an aunt or grandmother, female participants often preferred to avoid speaking to family out of fear of alienating the partner in the eyes of family members.

> *"I would only tell my sister once I have managed to resolve the issue and it has passed. I would not want to tell her as it in unfolding as she would be quick to say end the relationship. I feel she would be*

overprotective and end up blowing it out of proportion in a bid to do what is in my best interests."

- Female Immersion Participant, Zimbabwe

Women in South Africa were less likely than participants in other countries to report having a close confidant

Female participants in South Africa exhibited higher levels of guardedness about confiding in members of their intimate social network. As a result, South African participants were more likely to not have anyone they can really confide in, and no safe space where they can really speak and share without the fear of being exposed.

This may be connected to the relatively greater importance placed by South African female participants on preserving their public image. Female participants also described seeing how celebrities in popular culture will go from being friends one minute to enemies the other. This is something that several women have experienced personally. Finally, conversations also provided evidence of women in South Africa feeling that they themselves might be blamed if their partner was found to be cheating.

5.5. PRODUCTS THAT USERS ACCESS ALONGSIDE SRH PRODUCTS

5.5.1 DESK REVIEW FINDINGS SUMMARY

The review did not identify any published data indicating the types of products that women in the three countries use or purchase alongside SRH products. Available data on service delivery channels for OCP collection[10] across the three markets indicated that contraceptives are strongly associated with healthcare products. Other marketing campaigns created branded products designed to help women use SRH products discreetly (see Figure 1).

FIGURE 1: PRODUCTS CREATED AS PART OF THE V-CAMPAIGN

5.5.2 NEW CONTRIBUTIONS FROM PRIMARY RESEARCH

Both PrEP and OCP are generally framed and perceived as a form of medicine

It was common for participants to compare (and sometimes confuse) PrEP with ARVs. Indeed, this association has led some women to question why they should be expected to take PrEP once a day to prevent acquisition of HIV, when this is no different in their minds from taking daily ARVs to manage HIV.

In general, SRH products were commonly stored alongside beauty products and medicines in female participants' homes (see **Error! Reference source not found.**).[11]

FIGURE 2: PRODUCTS IN CONTEXT IN FEMALE PARTICIPANTS' HOMES

[10] See pg. 52 of this report for a summary.
[11] Top left – OCP user, Kenya; far-right – OCP user, SA; bottom left – PrEP user, Zimbabwe; bottom middle – OCP user, SA.

Women commonly decant pills into a container of their own choosing, rather than leave it in the original packaging

This behaviour was also reported in the secondary literature and is motivated primarily by women's desires for secrecy and privacy, but also by convenience, as its easier to carry a strip of pills around rather than the full box. Female participants reported avoiding containers that rattle (e.g. pill bottles) out of concern that others would hear the noise and assume they were ARVs. Women generally preferred blister packs, which they then removed from the box and kept in a wallet or a bag. In other cases, female participants did not decant pill bottles, but still found other ways to conceal the bottle itself, for example hiding it in a shoe.

FIGURE 3: FEMALE PARTICIPANT PRODUCT STORAGE PHOTOS

Female participants' storage spaces indicate an opportunity to replace ad-hoc or generic storage containers (e.g. shoes, bags) with more bespoke or branded alternatives (e.g. via brand partnerships with healthcare and beauty brands) (see **Error! Reference source not found.**).[12]

Extensive planning underpins participants' usage of SRH products

For example, mobile phones were among the most mentioned objects associated with use of OCP and PrEP, as they are commonly used to set reminders to take pills. Some reported only taking OCP/PrEP intermittently and in response to planned sexual encounters. One female participant in Kenya reported starting PrEP seven days before meeting with her "side-man," and then immediately discontinuing.

Data reiterated the importance of distancing the DPP's look and feel from PrEP

As much as possible, the DPP should be designed, packaged and branded to resemble a contraceptive rather than PrEP. Participants preferred blister pack packaging to a PrEP bottle for DPP design prototypes. They were generally happy with the look of the pills, although some called for the DPP to look more like a food supplement. Packaging the DPP as OCP+ with the added benefit of HIV protection,

[12] Top left – PrEP user, SA; bottom left – PrEP user, SA; top right – PrEP user, Kenya; bottom right – PrEP storage, SA.

rather than paying equal attention to OCP and PrEP, may allow women to present the DPP as contraception, leveraging that many female participants are more worried by pregnancy than HIV and dissociating the DPP from stigma associated with HIV/PrEP.

6. DPP DEMAND GENERATION AND MARKETING CONSIDERATIONS

This section outlines how key insights in this report could be translated into opportunities for the DPP demand generation and marketing strategy. These considerations are indicative communications opportunities only, based on learnings from the research so far, and will be explored further in the next research phase with end users, in-country media and creative agencies, and tested for feasibility in market.

1. OVERALL POSITIONING OF CATEGORY / DPP BRAND

Connect with different sides of women's identities

For women to want to take the DPP, it is not enough for them to believe in the health benefits. Women need to believe that the DPP aligns with their values, beliefs and identities, and that they can take the pill without damage to their social status or reputation.

Research shows that when deciding whether to use the DPP, end users are likely to juggle competing sets of values, including self-focussed values such as career goals and enjoyment, and community-focussed goals, such as religious and traditional values. Therefore, there is a big opportunity to show that instead of aligning with just one set of values, the DPP helps women navigate the competing values in their lives.

Connect the DPP with relationship goals

Both primary and secondary research showed that the risk of damaging a relationship often felt more immediate and was a stronger influence on behaviour than health risks such as HIV, which many discounted because it felt distant or "wouldn't happen to me." This was particularly significant given the personal and social status attached to being in a relationship and the family values associated with this.

Currently, OCP/PrEP are seen as products which can put people's relationships at risk, e.g. because it is a sign that they do not trust their partner or are cheating on them. There is a role for communications to flip this perception, showing that those who take the DPP are doing so because they care about their partner and want to protect the relationship, e.g. by delaying children until the couple is ready for them.

Connect the brand to people's aspirations and lifestyle goals

End users spend much more time thinking about personal aspirations than potential health risks. For instance, when talking about their values, identity and aspirations, participants focused on achievements such as career goals and financial security, and enjoyment, including sexual pleasure, travel and enjoying the "finer things" in life.

For the DPP to have a greater share of mind, we could connect it to their aspirations and goals, showing how the DPP helps them to be ready for the negative shocks, such

as a partner's infidelity, so that it does not interrupt the things they want to focus on such as career and enjoyment.

Leverage different triggers/need states for media targeting

Although some respondents pointed to positive triggers for taking up OCP/PrEP, such as having their first child with their husband, most triggers related to negative experiences in people's lives. For instance, suspecting or discovering a partner's infidelity was the most common trigger referenced by participants. While we may want to build positive associations with the brand, developing messaging which targets positive triggers, these more negative triggers represent significant category entry points which we can seek to target through media placement.

Use OCP as an entry point for DPP rather than PrEP

Use of PrEP is surrounded by greater stigma and negative associations than OCP. HCWs and end users suggested that it would be easier to increase acceptability of the DPP in market if pregnancy prevention is positioned as the primary benefit, and HIV prevention as secondary; for instance, by positioning the DPP as OCP+ with the added benefit of HIV prevention, with packaging branded to resemble a contraceptive rather than PrEP.

2. PRODUCT ATTRIBUTES, SERVICE DELIVERY AND DISTRIBUTION

Design packaging like products in the food supplement or beauty category

All research participants highlighted the importance of being able to conceal OCP/PrEP, e.g. from family members or male partners. Because of this, they preferred the suggested packaging design in a blister pack rather than a bottle, as the pills would not rattle. To make the product easier to hide, they also expressed a desire for product packaging not to look like medication. Suggestions included making it look like a food supplement, vitamin or Omega 3 container, or borrowing from the beauty category, e.g. a container which looks like a make-up bag.

Equip HCWs to support women through the challenges of taking the DPP

Some of the HCWs we spoke to highlighted that for OCP/PrEP to be adopted effectively, they needed to be more than a point of access for SRH products. They needed to be life counsellors who helped women overcome mistrust of products due to fear of side effects or misinformation, as well as support them in adhering to the product where there is limited acceptance from their partner or family.

Not only will communications need to educate HCWs about the benefits of the DPP and increase awareness and acceptance among them, but we should equip HCWs with messaging to support women to navigate potential challenges of taking the DPP.

Scale up the DPP at preferred private distribution channels

Most participants spoke of visiting the health clinic when they first made the decision to access SRH products. However, following this first interaction, many preferred to access products through private channels such as pharmacies. Therefore, it will be

important to equip HCWs with the right training and communication materials to ensure the first point of contact is a positive one, but rapidly scale distribution at preferred points of access such as pharmacies, leveraging compelling point-of-sale communications in these spaces, as well as more informative communications about pill usage and side effects which women who access the DPP through private channels can take away with them.

3. INFORMATION / PROMOTIONAL CHANNELS

Create central points of access for trusted information, beyond the information provided by HCWs

User journeys show that once women are actively seeking information about SRH products, they often gather information online, via Google, Facebook, and WhatsApp, and from close confidants such as a best friend or older sister, even before they seek medical advice from a nurse at the local clinic. This creates space for myths and rumours to circulate, for example, about side effects or effects on female fertility.

To counter this risk, it will be important to create places where people can easily access credible information about the DPP before visiting the clinic, for example, on a social media page or website.

Expand to channels that offer greater privacy for sharing information on sex and relationships

Due to nervousness about being seen by others to take OCP/PrEP and to be negatively judged by male partners or others in the community, many women preferred to talk about their own SRH decisions in private settings.

For instance, anonymous online health groups were particularly popular in South Africa, as were conversations with hairdressers and manicurists in Kenya and Zimbabwe. We could partner with these channels to support women in accessing engaging and accurate information in private settings where they feel comfortable talking about SRH issues, with people they trust.

Utilize channels beyond the health sector to reach people in their day-to-day lives

Research showed that women form opinions and preferences for specific SRH products far in advance of their first visit to the health clinic, with little evidence of female participants later changing their minds about a particular product preference. Therefore, it is critical that communications intervene before women are actively considering SRH options.

Recommended touchpoints for communications identified in the research include: bridal parties / baby showers; while watching TV / films with partner / friends; nights out; dating apps; entrepreneur / networking events; listening to music; Church / bible groups; community dialogues / meetings; leisure time with the family / with children; playing / watching sports; spending time on grooming / beauty (e.g. hair salons).

4. INFLUENCER AND COMMUNITY ENGAGMENT

Leverage trusted members of their network as advocates for the brand

Across all three countries, women spoke of having one or two close confidants that they would go to for information and advice about SRH. Typically, this is a close friend or older sister who has been through a similar journey navigating sex, relationships and use of SRH products. In more rural settings, women often receive advice from aunties, sengas or mamacanes (mother's younger sister) due to more closed conversations with their mothers.

We could draw on these members of the network as advocates and champions for the brand, positioning them as trusted sister or aunty figures who can provide anonymous support and advice to end users. Equally, we can encourage women to share information about the DPP with their confidants, e.g. providing them with social media or WhatsApp content they can pass on to those they care about and want to protect. At community level, we could also cascade messages about the DPP through trusted members of the community, e.g. discussions with community and religious leaders who are potential points of tension.

Turn supportive male partners into advocates for the brand

At societal level, we found significant male resistance to the idea of the DPP, for instance because it could be seen to give women greater license to cheat on their partner and therefore threatened masculine gender norms. However, at an individual level, many male participants we spoke to (particularly younger, urban individuals with a higher socio-economic background) recognised that their extra-marital affairs put their partner at risk and expressed more supportive attitudes towards the DPP.

To increase the acceptability of the DPP among men, we could develop a strand of communications activity targeting men, which positions the DPP in a way which is consistent with their values and beliefs, as well as leveraging men who are individually more supportive of the DPP as champions for the product. These communications can also include reassurance and myth-busters to counteract fears about the effect of the pill on male and female fertility and libido.

Shift perceptions about who is likely to take the DPP

Although many research participants held more positive opinions about OCP/PrEP users at an individual level, all noted the widespread social stigma that persists, with women on PrEP associated with the type of person who has sex before marriage, already has HIV or is promiscuous. To increase the social acceptability of the DPP, there is a need to counteract existing negative perceptions and build a new set of positive associations around those taking it. Suggestions made by research participants included associating the DPP with women who are thinking of their children's futures or their own career, who are health conscious or just savvy about protecting themselves from male partners' risky behaviours.

7. ANNEXES

7.1. ANNEX 1: RESEARCH PARTICIPANTS

7.1.1 IMMERSION PARTICIPANT PROFILES

7.1.1.1 KENYA

IMMERSION #	LOC	URB/RUR	SEX	PRODUCT	AGE	SEC
1	NBO	URBAN	F	OCP	28	C1
2	NBO	URBAN	F	OCP	30	AB
3	NBO	URBAN	F	OCP	35	C1
4	NBO	URBAN	F	PrEP	20	C2
5	NBO	URBAN	F	PrEP	33	B2
6	NBO	URBAN	F	Non-user	20	B
7	NBO	URBAN	F	Non-user	26	C2
8	NBO	URBAN	M	N/A	40	C1
9	KIS	RURAL	F	OCP	26	AB
10	KIS	RURAL	F	OCP	35	C1
11	KIS	RURAL	F	OCP	30	C1
12	KIS	RURAL	F	PrEP	40	C2
13	KIS	RURAL	F	PrEP	33	B
14	KIS	RURAL	F	Non-user	33	C2
15	KIS	RURAL	M	N/A	33	C1

7.1.1.2 SOUTH AFRICA

IMMERSION #	LOC	URB/RUR	SEX	PRODUCT	AGE	INCOME BRACKET
1	JOH	URBAN	F	OCP	35	4
2	JOH	URBAN	F	Non-user	25	2
3	JOH	URBAN	M	N/A	32	5
4	JOH	URBAN	F	PrEP	28	3
5	JOH	URBAN	F	OCP	30	5
6	JOH	URBAN	F	OCP	34	4
7	JOH	URBAN	F	Non-user	31	4
8	JOH	URBAN	F	PrEP	21	4
9	KZN	RURAL	F	OCP	31	3
10	KZN	RURAL	F	OCP	37	2
11	KZN	RURAL	M	N/A	39	3
12	KZN	RURAL	F	PrEP	25	2
13	KZN	RURAL	F	PrEP	36	4
14	KZN	RURAL	F	Non-user	30	3
15	KZN	RURAL	F	OCP	27	3

7.1.1.3 ZIMBABWE

IMMERSION #	LOC	URB/RUR	SEX	PRODUCT	AGE	INCOME BRACKET
1	HAR	URBAN	F	OCP	38	5
2	HAR	URBAN	F	Non-user	26	6
3	HAR	URBAN	F	Non-user	28	4
4	HAR	URBAN	F	PrEP	33	Refused
5	HAR	URBAN	M	N/A	29	4
6	HAR	URBAN	F	PrEP	33	3
7	HAR	URBAN	F	OCP	40	6
8	HAR	URBAN	F	OCP	37	5
9	BUB	RURAL	F	PrEP	29	2
10	BUB	RURAL	F	PrEP	23	3
11	BUB	RURAL	M	N/A	22	2
12	BUB	RURAL	F	PrEP	31	2
13	BUB	RURAL	F	Non-user	22	2
14	BUB	RURAL	F	OCP	21	3
15	BUB	RURAL	F	OCP	24	3

7.1.2 HCW KII PARTICIPANT PROFILES

COUNTRY	#	LOC	URB/RUR	OCCUPATION
KE	1	NBO	URBAN	NGO HCW
KE	2	NBO	URBAN	Clinical officer
KE	3	NBO	URBAN	Nurse
KE	4	NBO	URBAN	Nurse
KE	5	KIS	RURAL	Clinical officer
KE	6	KIS	RURAL	Nurse
KE	7	KIS	RURAL	Clinical officer
KE	8	KIS	RURAL	Nurse
SA	1	JOH	URBAN	Doctor
SA	2	JOH	URBAN	Nurse
SA	3	JOH	URBAN	Nurse
SA	4	JOH	URBAN	Pharmacist
SA	5	KZN	RURAL	Nurse
SA	6	KZN	RURAL	Doctor
SA	7	KZN	RURAL	Nurse
SA	8	KZN	RURAL	Nurse
ZIM	1	HAR	URBAN	Doctor
ZIM	2	HAR	URBAN	Pharmacist

ZIM	3	HAR	URBAN	Nurse
ZIM	4	HAR	URBAN	Nurse
ZIM	5	BUB	RURAL	Nursing officer
ZIM	6	BUB	RURAL	Village Community HCW
ZIM	7	BUB	RURAL	Nurse
ZIM	8	BUB	RURAL	Nurse

7.1.3 CULTURAL COMMENTATOR KII PARTICIPANT PROFILES

COUNTRY	METHOD	#	NAME	OCCUPATION	USEFUL LINKS
KE	CC KII	1	Gertrude Mungai	Lifestyle designer on sex and relationships. She is also a wife, mother, author / blogger, TV and radio host and motivational speaker.	https://twitter.com/i/status/1309762339277856768 https://youtu.be/5uB9waiHW6A https://youtu.be/Cq6g178HJtU https://youtu.be/myRnBto78Ug_K24
KE	CC KII	2	Apondi Nyang'aya	Life skills coach, facilitator and trainer. Runs a "Mum and Me" segment with a daughter where they give advice on different topics about life like marriage, culture, money and sexual health, for example at bridal showers and other female occasions / talks.	https://www.pd.co.ke/lifestyle/mother-daughter-duo-big-on-impact-69927/ https://www.youtube.com/watch?v=YGLyMx1anZA https://www.youtube.com/watch?v=297UTnTq8aU https://www.youtube.com/watch?v=ze2unRbPuek
KE	CC KII	3	Maurice Matheka	Sex and relationship therapist, specializing in relation psychology, sexual psychology and sexual application.	https://nation.africa/kenya/maurice-matheka-1574 https://youtu.be/_NBP6lUSlvY https://youtu.be/5azGIFo_Ecs
SA	CC KII	1	Prefer to remain anonymous	Senior Manager, Human Sciences Research Council	
SA	CC KII	2		Senior Manager, Soul City Institute	
SA	CC KII	3		Community PrEP Adherence Facilitator	
ZIM	CC KII	1	Prefer to remain anonymous	Health Centre Committee Member	
ZIM	CC KII	2		Senior Social Services Officer	
ZIM	CC KII	3		Hair Salon Manager	
ZIM	CC KII	4		Community Elder	

7.2. ANNEX 2: NOTES ON APPROACH AND METHODOLOGY

7.2.1 RESEARCH APPROACH

The design of the qualitative study was guided by three elements.

1. Ethnographic Approach

The research design was guided by an ethnographic approach which emphasised building trust and understanding between researchers and participants through repeat engagements, time spent in the field and the pursuit of a holistic understanding of participants as situated within their cultural context.

2. HCD Principles and Techniques

The design also drew on HCD principles and techniques to ensure that all insights and subsequent recommendations for the demand generation and marketing strategy were grounded in an empathetic understanding of the lived realities of the target audience.

3. Do No Harm

Finally, the design adhered strictly to Do No Harm principles, with ethical approval of the research design sought and granted by relevant authorities[13] in all three markets prior to the commencement of fieldwork in that market.

Owing to variations in the time for approval to be granted in each market, fieldwork commenced and was completed first in Kenya, then in South Africa and finally in Zimbabwe. Fieldwork conducted later in this sequence was informed by learnings and feedback generated in earlier stages, with the research team following an iterative approach to adapting and updating the research design and fieldwork process.

7.2.2 LOCATIONS, SAMPLE AND METHODS

Research was conducted in one urban and one rural location in each country. Locations were selected by shortlisting regions and provinces in each country in which the Total Addressable Market for Contraception (TAMC) for female 15–49-year-olds constituted a relatively large proportion of the population, and which had a relatively high HIV prevalence rate for female 15–49-year-olds.[14] These shortlists were then reviewed by the consortium and AVAC to identify preferred regions and provinces,

[13] Daystar University Ethical Review Board and the National Commission for Science, Technology and Innovation (NACOSTI) in Kenya, the Human Sciences Research Council (HSRC) in South Africa and the Medical Research Council of Zimbabwe (MRCZ) in Zimbabwe.

[14] Data on these indicators was gathered using the Multi-Purpose Target (MPT) Population Identification Mapping Tool, developed by the IMPT Secretariat along with partners at Public Health Institute's Survey Research Group (PHI SRG) and USAID. The tool can be accessed here: https://theimpt.org/mpt-target-population-identification-mapping-tool/.

after which the local field research teams provided recommendations for specific districts within those locations to form the focus of the research. **Error! Reference source not found.** provides an overview of the final study locations selected for each country.

TABLE 7: RESEARCH LOCATIONS

Country	Kenya	South Africa	Zimbabwe
Urban location	**Nairobi**	**Gauteng Region** - City of Johannesburg	**Harare**
Rural location	**Nyanza Province** – Rural locations around Kisumu	**Kwazulu-Natal Region** - uMgungundlovu, uMzinyathi, Uthukela and Ilembe Districts	**Matabeleland North Region** – Rural locations around Bubi

Research was conducted with multiple audience categories, using a variety of research methods. Audience categories included:

- **Women aged 20-40**, split into three sub-categories based on their product usage: current users of OCP, current users of PrEP and users of neither product or any other long-acting reversible contraceptive (LARC)
- **Male romantic partners** of women aged 20-40
- **HCWs** currently providing contraception and/or HIV prevention services. These included doctors, nurses, pharmacists and HCWs working for NGOs.
- **Cultural Commentators (CCs)** able to provide insights into the trends, nuances and idiosyncrasies that define how sex, relationships and SRH are thought and talked about in their countries[15]

Research methods included:

- **1-1 immersions** conducted face-to-face with women aged 20-40 and male romantic partners, comprising two separate sessions with each participant
- **Friendship circles** conducted face-to-face, bringing together an immersion participant and the friends, peers and relatives of their choosing
- **Key informant interviews (KIIs)** with HCWs and CCs, conducted either face-to-face or via Zoom

Table 8 provides an overview of the research sample per country. In total, the research sample in each country incorporated:

- Immersions with **13 women** aged 20-40 per country (**39 total**)
- Immersions with **2 male romantic partners** per country (**6 total**)
- Group discussions with **2 female and 2 male friendship circles** per country (**12 circles total**)
- KIIs with **8 HCWs** per country (**24 total**)

[15] See Annex 1 for a detailed breakdown of the research participants per country.

- KIIs with **3 cultural commentators** per country (**9 total**)

TABLE 8: RESEARCH SAMPLE AND METHODS

Method	Participant Profile	No of participants per country	
		Urban Loc.	**Rural Loc.**
Immersion (2 x sessions per participant)	Current OCP users	3	3
	Current PrEP users	2	2
	Unmet FP need (incl. emergency contraception users)	2	1
	Male romantic partners	1	1
	Total immersions	**8**	**7**
Friendship circle	Female immersion participant + friends	1 circle	1 circle
	Male romantic partner + friends	1 circle	1 circle
Key informant interview (Zoom or face-to-face)	Healthcare Workers	4	4
	Cultural commentators	3	

7.2.3 HUMAN-CENTRED DESIGN EXERCISES

Research participants often struggle to have open and honest conversations about sex, relationships and SRH, owing to the oftentimes sensitive and private nature of these subjects as topics of conversation. Moreover, understanding an individual's journey into, through and out of market categories like contraception and HIV prevention is often challenging without the use of tools that help to systematize these journeys and provide users with templates with which to order their narratives.

To address these challenges, it was necessary to provide local researchers with more than a traditional question guide. In addition, researchers employed a variety of HCD exercises designed to facilitate discussions with participants. These exercises are

summarised below, with illustrations of the outputs generated during researchers' conversations with participants.[16]

[16] To request a full copy of the research protocol, including both the questions guides and instructions for using the HCD tools, please email kate@avac.org.

7.2.3.1 SOCIAL NETWORK MAPPING

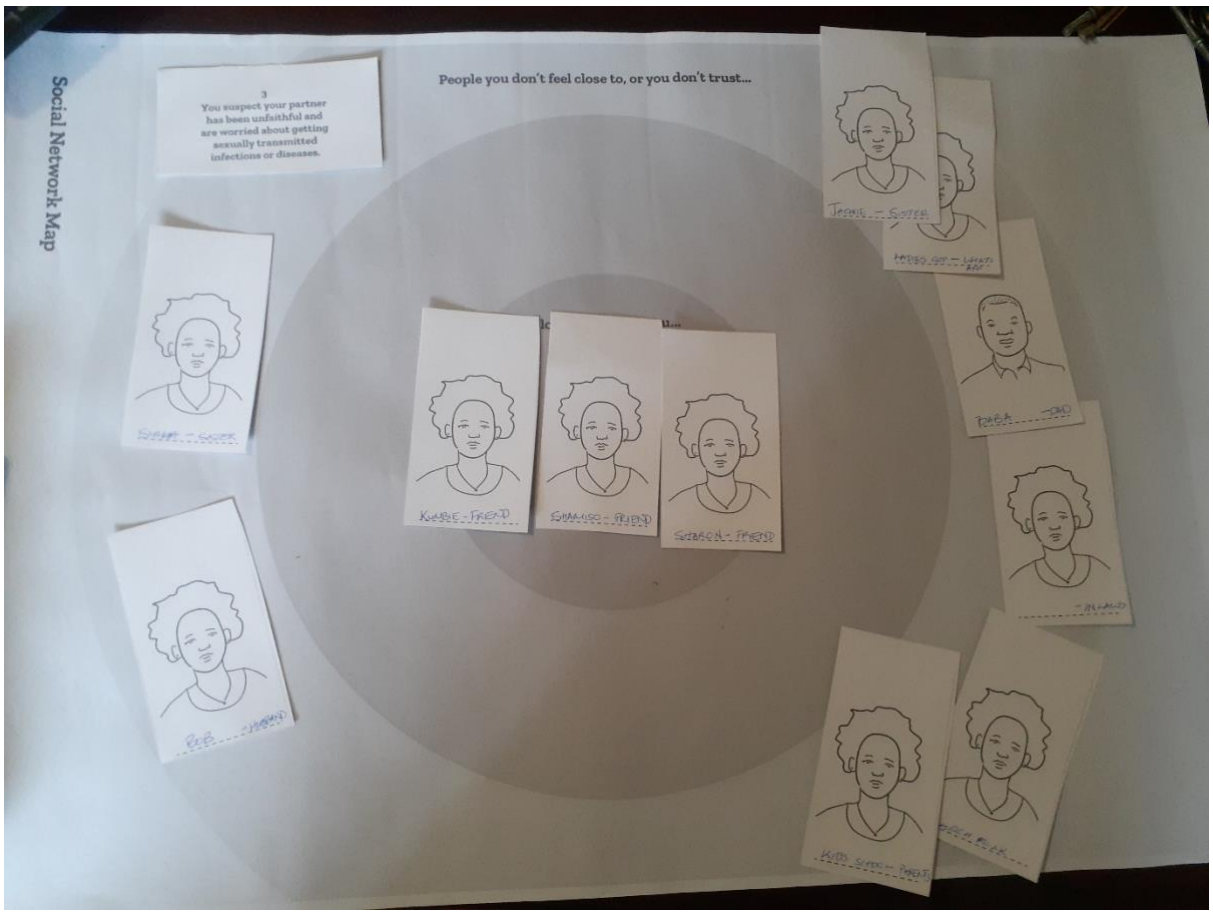
A social network mapping exercise was used to investigate who immersion participants would seek advice from (and who they would avoid) in different scenarios, in order to understand who influences them and their level of trust in different people in their network of influence (see Figure 2). This exercise was used with both male and female immersion participants.

Participants were invited to arrange cards representing different people in their social network on a map made up of concentric circles. Proximity to the centre of the map correlates with how trusted that person is in a given scenario: the closer to the centre, the most trusted and likely the participant would be to seek advice from them.

Participants were asked to repeat the exercise in response to four scenarios.

- **Scenario 1:** You have been feeling unwell for a few days and are not sure what is wrong.
- **Scenario 2:** You want to delay having a child/your next child.
- **Scenario 3:** You suspect your partner has been unfaithful and are worried about getting sexually transmitted infections.
- **Scenario 4:** You and your partner disagree about using condoms.

FIGURE 2: COMPLETED SOCIAL NETWORK MAP EXAMPLE – CREATED BY A FEMALE PARTICIPANT FROM HARARE, ZIMBABWE



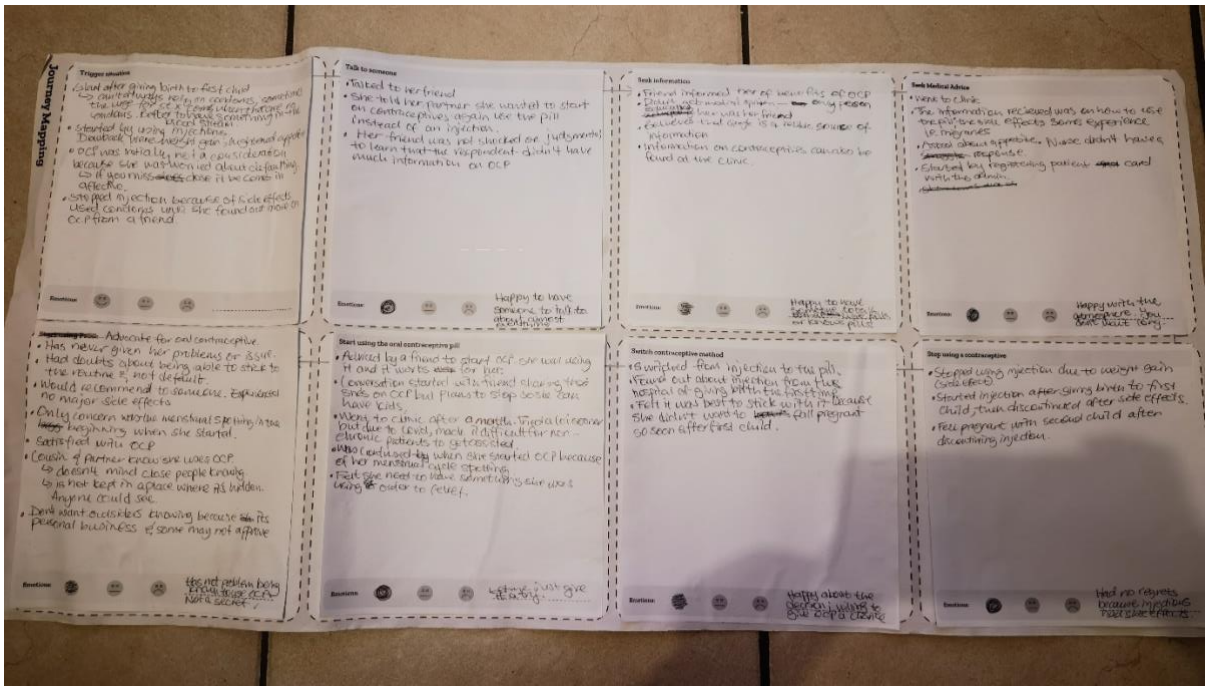
7.2.3.2 JOURNEY MAPPING

A journey mapping exercise was used to investigate how participants came to use PrEP and/or OCP and their experiences using the product (see Figure 3). More specifically, the exercise was used in this study to explore:

- The **triggers** that led participants to consider and ultimately decide to use the SRH product
- Participants' **experiences** at different points on their journey, both in terms of **what happened** and **how they felt** at the time
- The **sources of information** (people, medical professionals and media) used by participants throughout their journey
- The **places** visited at different points in the journey.

The exercise works by providing the researcher and the participant with a journey template and a set of prompt cards to populate that template. These prompt cards require the researcher (or the participant, depending on their literacy level) to make notes on the card and to arrange them in a visual representation of their journey into and through the category. These notes include descriptions of what happened at a particular stage of the journey, as well as how the participant felt at the time.

FIGURE 3: COMPLETED JOURNEY MAP EXAMPLE – CREATED BY A FEMALE PARTICIPANT FROM KWAZULU-NATAL (KZN), SOUTH AFRICA

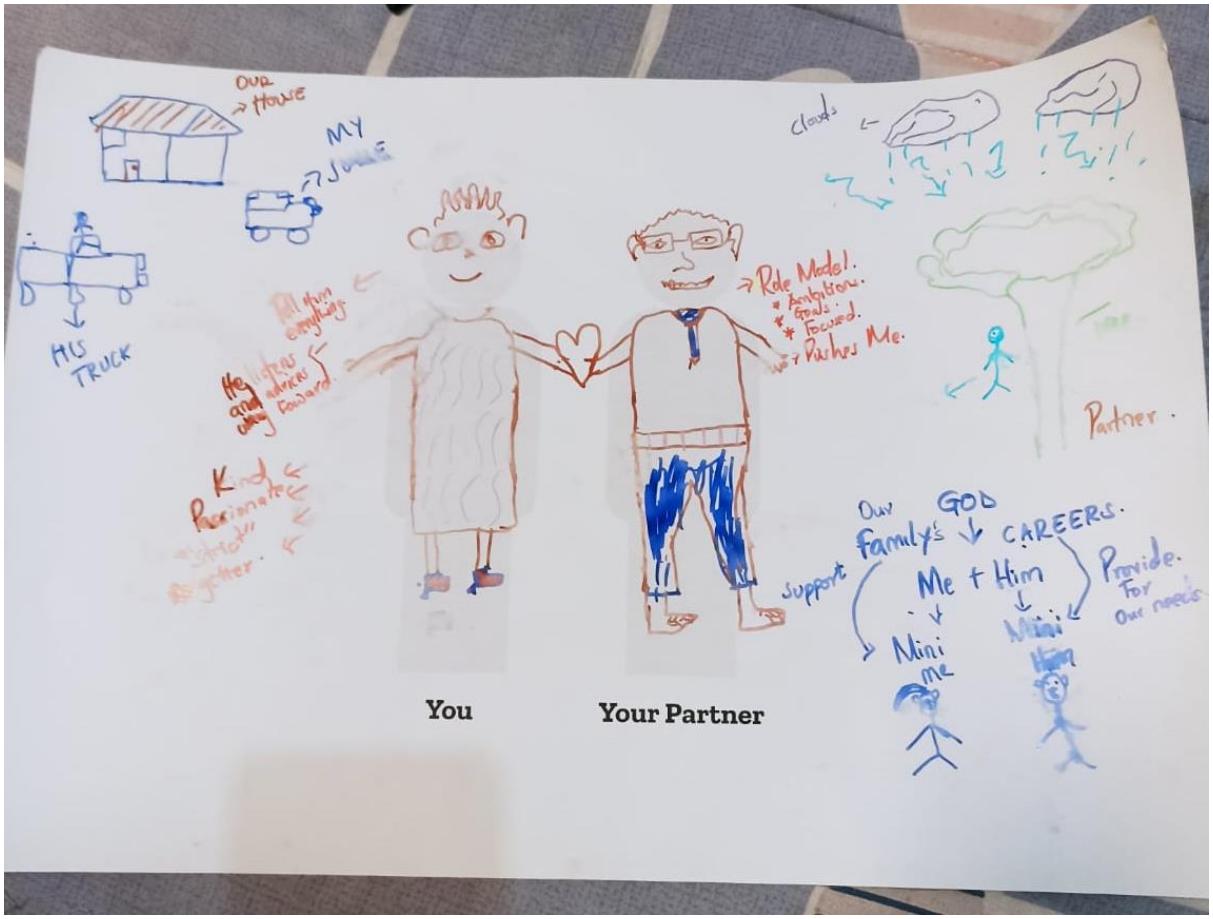


7.2.3.3 ‘MINI-MES’

The Mini-Me exercise was used to explore the personal values and relationship goals of both male and female participants (see **Error! Reference source not found.**). This exercise was originally reserved for non-users of PrEP or OCP, both male and female. However, after Kenya fieldwork was completed, the decision was made to encourage researchers to use the exercise with all participants with whom they believed it would help extract useful insights. Consequently, a greater number of ‘Mini-Me’s’ were generated in South Africa and Zimbabwe.

The exercise provides the participant with a template on which to draw and annotate him or herself (their ‘mini-me’) and their partner. The researcher asks questions to encourage the participant to think about their personal values, aspirations, roles and responsibilities, as well as the values and roles they wish for their ideal partner.

FIGURE 4: COMPLETED MINI-ME EXERCISE EXAMPLE – CREATED BY A FEMALE PARTICIPANT FROM KISUMU, KENYA



7.2.4 SOURCES OF DATA

The insights presented in this report are informed by six sources of data. Sitting behind these data sources are two key principles of the research approach:

- **Principle 1 – Avoid reinventing the wheel:** This research sought at all points to avoid reinventing the wheel by maintaining a focus on unanswered questions, as opposed to simply reproducing data and evidence already provided in the secondary literature.
- **Principle 2 – Ground all insights in local expertise and experience:** This research is the product of collaboration between UK-based and local researchers from Kenya, South Africa and Zimbabwe. For research that is qualitative and ethnographic in its approach, the local expertise and experience of researchers who know the local context is of paramount importance.

Six data sources informing this report

1. **Formative Desk Review**

The desk review conducted by M&C Saatchi World Services drew out a wealth of findings related to the study's key learning questions. Many of these findings were echoed in conversations with research participants.

To avoid duplicating these findings and to focus on the new contributions of this research, each subsection of Section 5 (Research Insights) begins with a summary of the relevant findings from the desk review. A full copy of the desk review is also available on request.[17]

2. **Local Researcher Field Notes**

Local researchers in Kenya, South Africa and Zimbabwe kept field notes that recorded their key findings and insights, which were shared with the wider consortium either as written documents or voice notes.

During the analysis, members of the research team at M&C Saatchi World Services remained in constant communication with the field researchers to gather their perspectives and feedback on key questions as and when required.

3. **Local Researcher Data Download Sessions**

To maximise opportunities for the analysis process to benefit from the expertise and experience of the field researchers themselves, a series of data download sessions were convened. These sessions were led by Moowa Masani, Founder of REACH Insights, and were attended by the field researchers in each country as well as members of the M&C Saatchi World Services team.

Three download sessions were conducted per country: one following initial pilot immersions, one mid-way through fieldwork and one once all fieldwork was completed. Each session lasted between 2-3 hours and was conducted via Zoom.

During each session, field researchers provided an overview of the key findings emerging from the research. These findings were then interrogated in an open

[17] To request a copy of the report, please email kate@avac.org.

discussion to identify implications for the roll-out of the DPP as well as considerations and recommendations for the Demand Generation and Marketing Strategy.

4. HCD Exercise Outputs

Field researchers took photos of the final outputs from each HCD exercise described above. The data from these photos was then systematically analysed by, for example:

- Transcribing the responses to the Social Network Mapping exercises to identify patterns in terms of where different members of participants' social networks were positioned for the different scenarios
- Sorting all of the HCD journeys based on their trigger points and analysing the resultant categories for common themes
- Manually coding all of the values expressed in the Mini-Me's.

This analysis was a collaborative effort undertaken by members of the research team from M&C Saatchi World Services and Humanly.

5. Other Photographic Data

During fieldwork, field researchers asked permission from participants to take photos of, for example, their local surroundings and where they store their SRH products. In cases where permission was granted, these photos were taken and sent to M&C Saatchi World Services for further analysis.

6. Transcripts Review

Finally, field researchers provided transcripts of their conversations with research participants. These transcripts were reviewed by M&C Saatchi World Services and Humanly to supplement data and evidence generated via the sources described above, and to identify supportive and illustrative quotations.

7.3. ANNEX 3: NOTES ON PERSONA AND JOURNEY DEVELOPMENT

7.3.1 FIVE STEPS FOR PERSONA AND USER JOURNEY DEVELOPMENT

The DPP user personas and journeys generated by this research are the product of a systematic process comprising five steps.

1. **Conducting a rapid analysis of the values and aspirations** of both male and female immersion participants to understand their most important drivers and values and to examine how these interact with SRH goals. This analysis concentrated primarily on data generated by the 'Mini-Me' exercises and conversations with participants about their personal values.
2. **Examining and collating the barriers to SRH product uptake and adherence** reported at various points in the research, including the desk review; conversations with male and female participants, HCWs and cultural commentators; social network mapping and user journey exercises.
3. **Categorising the user journeys based on trigger moments for product entry**. Five trigger categories were identified: new mothers (planned pregnancy); unintended pregnancy; maintaining the relationship; unfaithful partner and seeking enjoyment outside of marriage. See Annex 2 for a breakdown of the number of user journeys sorted into each category by country, urban/rural setting and product usage.
4. **Developing a matrix to guide user journey development.** This matrix was designed to ensure that the final user journeys reflected the diversity of the data generated by the research, for example, in terms of the various triggers, participants' levels of awareness of product options and who they went to for advice and information. See next page for a copy of the matrix.
5. **Linking each user journey to a persona.** These personas were developed to highlight the most common category entry points, drivers and barriers which communications can tap into, informed by insights generated in Steps 1 and 2.

4.1	Vicky	New mother	Persona
4.2	Lindiwe	Maintain relationship	Persona
4.3	Thandiwe	Unintended pregnancy	Persona
4.4	Elsie	Enjoyment outside marriage	Persona
4.5	Faith	Unfaithful partner	Persona

7.3.2 USER JOURNEY MATRIX

The User Journey Matrix was developed to ensure that the final set of journeys generated by the research reflected the diversity of the data across nine dimensions.

TABLE 9: USER JOURNEY MATRIX

Matrix Dimension	PERSONAS				
	Faith	**Lindiwe**	**Elsie**	**Thandiwe**	**Vicky**
Trigger category	Untrustworthy partner	Maintaining relationship	Seeking enjoyment outside of marriage	New mother - Unintended pregnancy	New mother - Planned pregnancy
Product used	PrEP	PrEP	PrEP + OCP	OCP	OCP
Awareness of options at trigger moment	Low	Low	High for OCP, low for PrEP	Low	High
Primary influence on preferred product	HCW	Sister, HCW	Close friend	Older female relatives	Partner, HCW
Online research conducted?	No	Yes - to check what partner's medication is for	Yes - to look up how to deal with side effects	No	Yes - to form initial preferences
Partner aware of product usage?	No	Informed but not consulted	No	No	Actively consulted
Side effects experience	Moderate	None	No	Low	Severe
Product switch?	No	No	No	Yes	Yes
Other factors	Husband disapproves of condoms	Believes condoms reduce pleasure		Get OCP from source other than clinic	

7.3.3 A NOTE ON HOW PERSONAS AND JOURNEYS WILL INFORM NEXT PHASES

Both sets of research outputs are intended to provide creative stimulus for developing different messaging, messengers and touchpoints which leverage the insights they contain.

However, it is important to note that personas are not always useful or practical to target media against. Therefore, in subsequent phases of the project, M&C Saatchi World Services will work with its media agency partners to identify the best approaches to reach key audiences in effective and efficient ways (leveraging insight around media habits), which will feed into the marketing and demand generation strategy. This may not always correspond directly to specific personas.

It is also important to note that many audiences do not fit into a single persona, but rather cross between different personas at different moments in their day or at different life stages. Therefore, while the strategy and creative development process might focus on personas more likely to adopt the DPP, it is important that the overarching DPP brand is relevant to all personas so as not to exclude any one of them.

7.4. ANNEX 4: USER JOURNEY SORTING COUNTS

PERSONA		VICKY (New mother - planned pregnancy)	THANDIWE (Mother - unintended pregnancy	FAITH (Untrustworthy partner)	LINDIWE (Maintaining relationship)	ELSIE (Seeking enjoyment outside of marriage)
TOTAL (n = 28)		7	2	12	4	3
PRODUCT	OCP (n = 14)	7	2	1	3	2
	PrEP (n = 13)	0	0	11	1	1
COUNTRY	KE (n = 10)	2	1	4	1	2
	SA (n = 9)	1	1	3	3	1
	ZIM (n = 9)	4	0	5	0	0
LOCATION	Urban (n = 13)	3	1	5	3	1
	Rural (n = 15)	4	1	7	1	2

n = number of journeys categorised. A total of 28 journeys were analysed

7.5. ANNEX 5: DESK REVIEW DATA TABLES

This section presents results from of a quantitative re-analysis of the Demographic and Health Surveys (DHS) datasets from the most recent DHS surveys in the three countries (in Kenya, 2014; in Zimbabwe, 2015; in South Africa, 2016). The section also presents several other key data tables generated during the desk review.

The DHS secondary data analysis focussed in on the responses of women aged 20-40 to a selection of key questions, including:

- Appetite for family planning
- Current use of contraceptive methods
- Demographics, including age, education, wealth index, urban/rural
- Media frequency

The reanalysis was conducted with permission from the Demographic and Health Survey.

TABLE 10: CONTRACEPTION USE % BREAKDOWN OF 20-40 YEAR OLDS

	Kenya	South Africa	Zimbabwe
OCP user	6.6%	5.5%	34.7%
Other Contraceptive user	45.2%	51.1%	25.9%
Unmet FP Need	9.8%	7.3%	15.4%
No FP demand	38.4%	36.1%	24.0%

Source: DHS 2014-2016

TABLE 11: ESTIMATED NUMBER OF PREP INITIATIONS PER COUNTRY

	Kenya	South Africa	Zimbabwe
Estimated cumulative number of people initiating PrEP	128,000	370,195	59,918
PEPFAR 2021 Target	99,896	250,020	22,759

Source: data.prepwatch.org

TABLE 12: DEMOGRAPHIC AND MEDIA PROFILES: KENYAN WOMEN AGED 20-40 (DHS KENYA 2014)

KENYA			Women aged 20-40	Current Oral Contraceptive User (n=1,104)	Has an unmet contraceptive need (n=1,998)	HIV high risk (n=6,389)
			%	%	%	%
Demographics	Age in 5-year groups	20-24	**28.5**	20.1	51	37.4
		25-29	**30.3**	27.2	28.7	29
		30-34	**22.4**	26.9	13.1	18.5
		35-39	**18.8**	25.8	7.1	15.1
	Highest education	no education	**7.3**	1.6	11.3	5.8
		primary	**48.9**	46.7	40	52.6
		secondary	**29.5**	37.1	30.6	27.3
		higher	**14.3**	14.6	18.1	14.4
	Literacy	cannot read at all	**12**	4.6	15.7	12.6
		able to read only parts of sentence	**8**	5.4	7.1	9.6
		able to read whole sentence	**79.6**	89.4	76.9	77.4
		no card with required language	**0**	0	0	0
		blind/visually impaired	**0.1**	0.3	0	0.2
	Wealth Index	poorest	**14.7**	3.5	19.9	15.4
		poorer	**16.3**	11.4	15.4	17.3
		middle	**17.7**	16.1	15.7	19.9
		richer	**21.9**	24.7	20.1	20.6
		richest	**29.4**	44.4	28.9	26.7
	Urban/ rural	urban	**45.7**	56.9	45.2	44.4
		rural	**54.3**	43.1	54.8	55.6
Media Frequency	Newspapers/ Magazines	not at all	**61.8**	56.7	60.3	61.9
		less than once a week	**20.6**	24.2	20.1	20.6
		at least once a week	**17.6**	19.1	19.6	17.6
	Radio	not at all	**16.6**	9.5	21.5	15.8
		less than once a week	**12.1**	10.9	12.5	13.5
		at least once a week	**71.2**	79.6	66	70.7
	Television	not at all	**45.1**	30.2	47.4	46.4
		less than once a week	**12.4**	10.9	11.1	13.4
		at least once a week	**42.4**	58.9	41.6	40.1

TABLE 13: DEMOGRAPHIC AND MEDIA PROFILES: SOUTH AFRICAN WOMEN AGED 20-40 (DHS SOUTH AFRICA 2016)

SOUTH AFRICA			Women aged 20-40	Current Oral Contraceptive User (n=285)	Has an unmet contraceptive need (n=373)	HIV high risk (n=3,307)
			%	%	%	%
Demographics	Age in 5-year groups	20-24	27%	**19.6**	**47.2**	**32.6**
		25-29	27%	**34.3**	**27.6**	**29.1**
		30-34	25%	**26.4**	**20.4**	**21.7**
		35-39	20%	**19.8**	**4.8**	**16.5**
	Highest education	no education	1%	**0.8**	**1**	**1.1**
		primary	7%	**5**	**5.6**	**6.3**
		secondary	78%	**67.8**	**77.2**	**80.2**
		higher	14%	**26.4**	**16.2**	**12.4**
	Literacy	cannot read at all	3%	**1.3**	**1.7**	**2.5**
		able to read only parts of sentence	8%	**5.9**	**6.7**	**8.2**
		able to read whole sentence	90%	**92.7**	**91.4**	**89.1**
		no card with required language	0%	**0.2**	**0.3**	**0.1**
		blind/visually impaired	0%	**0**	**0**	**0.1**
	Wealth Index	poorest	18%	**14.9**	**12.9**	**20.5**
		poorer	22%	**14.6**	**22.9**	**23**
		middle	22%	**19.8**	**17.7**	**23**
		richer	20%	**18.3**	**26.8**	**20.4**
		richest	17%	**32.5**	**19.8**	**13.1**
	Urban/ rural	urban	69%	**76.7**	**70.8**	**64.7**
		rural	32%	**23.3**	**29.2**	**35.3**
Media Frequency	Newspapers/ Magazines	not at all	34%	**24**	**32.1**	**36.1**
		less than once a week	25%	**28.4**	**22.1**	**26.3**
		at least once a week	41%	**47.6**	**45.8**	**37.7**
	Radio	not at all	29%	**24.6**	**27.8**	**30.4**
		less than once a week	15%	**16**	**14.8**	**16**
		at least once a week	56%	**59.4**	**57.4**	**53.6**
	Television	not at all	17%	**11.6**	**12.8**	**17.6**
		less than once a week	9%	**10.6**	**7.8**	**10.6**
		at least once a week	74%	**77.8**	**79.4**	**71.9**

TABLE 14: DEMOGRAPHIC AND MEDIA PROFILES: ZIMBABWEAN WOMEN AGED 20-40 (DHS ZIMBABWE 2015)

ZIMBABWE			Women aged 20-40	Current Oral Contraceptive User (n=2,071)	Has an unmet contraceptive need (n=955)	HIV high risk (n=1,357)
			%	%	%	%
Demographics	Age in 5-year groups	20-24	27.3	**21.9**	**52.6**	**35.9**
		25-29	26.7	**27.2**	**25.8**	**27.9**
		30-34	26.1	**28.8**	**15.2**	**21.2**
		35-39	19.9	**22.1**	**6.5**	**15**
	Highest education level	no education	1	**0.9**	**1**	**2.2**
		primary	25.7	**25.5**	**23.5**	**37.4**
		secondary	64.1	**66**	**63.5**	**53**
		higher	9.2	**7.6**	**12**	**8**
	Literacy	cannot read at all	4.9	**5.3**	**4**	**9.7**
		able to read only parts of sentence	6.6	**6.5**	**5.5**	**9.3**
		able to read whole sentence	88.4	**88.1**	**90**	**80.8**
		no card with required language	0.1	**0.1**	**0.3**	**0.1**
		blind/visually impaired	0.1	**0**	**0.2**	**0.2**
	Wealth Index	poorest	17.8	**18.8**	**18.9**	**19.9**
		poorer	16.6	**17.9**	**15.3**	**19.4**
		middle	14.7	**14.1**	**13.5**	**14.4**
		richer	24.9	**26.2**	**21.4**	**24.9**
		richest	26	**23**	**30.9**	**21.4**
	Urban/ rural	urban	41.3	**38.8**	**43.5**	**38.1**
		rural	58.7	**61.2**	**56.5**	**61.9**
Media Frequency	Newspapers/ Magazines	not at all	56.3	**57.7**	**55.9**	**61.4**
		less than once a week	27.6	**28**	**25.9**	**24.7**
		at least once a week	16.1	**14.3**	**18.2**	**13.9**
	Radio	not at all	41.7	**37.9**	**42.9**	**46.5**
		less than once a week	22	**21.8**	**21.4**	**18.3**
		at least once a week	36.2	**40.3**	**35.7**	**35.2**
	Television	not at all	53.5	**55.1**	**52.6**	**57.1**
		less than once a week	13.6	**13.2**	**13.9**	**12.4**
		at least once a week	32.9	**31.7**	**33.4**	**30.5**

TABLE 15: DISTINCTIVE CHARACTERISTICS OF WOMEN AGED 20-40 WHO: USE OCP, HAVE AN UNMET NEED FOR FAMILY PLANNING OR ARE AT HIGHER RISK OF HIV

	KENYA	SOUTH AFRICA	ZIMBABWE
CURRENT OCP USERS	• **Older -** 35-39 overrepresented (26% of users vs. 18% of sample); 20-24 underrepresented (20% vs. 29%) • **Currently married –** overrepresented: 80% vs. 64% • **Better educated (up to secondary) -** Secondary level overrepresented (37%), no education under-represented (1.6%). Also higher literacy rates than average. • **Wealthy** – nearly half of users (44%) belong to the highest wealth quintile, compared to 29% sample average • **Urban** – 57% of users, overrepresented compared to the sample average (46%) • **Radio listeners** – 80% listen to radio at least once a week, higher than the sample average (71%) • **TV watchers** – 59% watch TV at least once a week, higher than the sample average (42%)	• **Older side of young – most 24-34, 25-29 overrepresented (34% vs. 27%)** • **Married or living with partners –** married AGYW overrepresented (38% vs. 23% sample average). 20% living with a partner. 40% never in a union (vs. 57% sample average). • **University educated** – 25% of users have a higher education, compared to 14% of the sample average • **Wealthy –** 33% in the top wealth quintile, vs. 17% of sample average • **Urban –** 77% of users, overrepresented compared to the sample average (69%) • **More likely to use media –** either once or less than once week	• **Youngest underrepresented –** 22% vs. 27%; confirms finding that younger AGYW are less likely to use, despite high usage generally • **High usage generally** means OC users are less niche than other markets • **9/10 married** – 90% 20-40 year old current OC users are married, compared to 71% of women aged 20-40 generally
UNMENT FAMILY PLANNING NEED	• **Younger** – 51% are between 20-24, compared to 29% sample average • **Skew towards unmarried (although still over half married)** - people who have never been in a union overrepresented (34% vs. 17%). Married people underrepresented (52% vs. 66%)	• **Younger** – nearly 1 in 2 (47%) aged 20-24, compared to 20% sample average	• **Younger** – 36% are between 20-24, compared to 22% sample average • **Less educated –** primary schoolers overrepresented (37% vs. 26%), secondary underrepresented (53% vs. 64%) • **Slight skew towards poorer wealth quintiles** – richest underrepresented (21% vs. 26%), poorest and poorer slightly overrepresented • **Lower literacy –** 2 in 10 either cannot read a full sentence, or can read it only partially • **Skews towards AGYW never in a union –** women with unmet need are 4x likely to have never been in a union than the sample average (32% vs 9%.). While 55% of are married, this is much lesss than the sample average (71%).
HIV RISK	• **Younger** – 37% are between 20-24, compared to 29% sample average. 35-39 year olds also underrepresented (15% vs. 26% sample average)	• **Younger** – nearly 1 in 3 (33%) aged 20-24, compared to 20% sample average	• **Younger** – 36% aged 20-24, compared to 27% sample average. • **Less educated –** 1 in 3 have attained primary school only, compared to 1 in 4 sample average

TABLE 16: PERCENT OF WOMEN AGED 20-40 WHO REPORT PUBLIC, PRIVATE AND COMMUNTY/OTHER CHANNELS AS THEIR LAST SOURCE OF CONTRACEPTION[18]

	Kenya		South Africa		Zimbabwe	
Audience Product Usage Profile	OCP users	Other FP method users	OCP users	Other FP method users	OCP users	Other FP method users
Public[19]	39%	58%	78%	81%	70%	74%
Private[20]	58%	26%	20%	9%	28%	22%
Community/Other[21]	3%	15%	2%	9%	3%	7%

TABLE 17: OUPUTS OF AVAC MARKET ASSESSMENTS

	Public	Private	NGO/Community
Kenya	Public sector clinics Youth centres/ corners	Private clinics Pharmacies	CHW facilities, outreach, mobile sites Community safe spaces
South Africa	Public sector clinics Youth Centers/ Corners Higher Education	Private clinics Pharmacies Higher Education	
Zimbabwe	Public sector clinics Youth Centers / corners Higher Education	Private clinics Pharmacies Higher Education	NGO clinics Projects for KPs

AVAC Market Assessments

[18] Calculated using the latest DHS Country Data available for Kenya (2014), Zimbabwe (2015) and South Africa (2016)

[19] In South Africa, the most commonly reported public channels were government healthcare clinics and hospitals. In Zimbabwe, the most common were rural health clinics specifically.

[20] In all three markets, the bulk of the share of OCP using women aged 20-40 who reported a private channel said their last source for contraception was a pharmacy.

[21] Community/other options captured by the DHS include: churches, shops, mobile clinics, community-based distributor, community health worker, friends, relatives.