

Step 3: Choose the Intended Audiences

Primary and Secondary Audience Segments (with rationale for segment selection)

In each country or sub-national context, choices will have to be made between female condom demand generation initiatives targeting general population and key population audiences. In countries with generalized HIV epidemics, for example in Eastern and Southern Africa, normalizing the female condom, e.g. by mainstreaming it at condom and contraception outlets, has the potential to increase the overall number of sex acts protected by any condom. Targeting female condoms to specific audiences, such as female sex workers, discordant couples, or concordant positive couples, primarily as an HIV prevention tool, can have impact and be cost effective in either generalized or concentrated epidemic settings.

PRIMARY AUDIENCES

A – General Population Audiences in Generalized HIV Epidemics

Primary Audience 1: Women of Reproductive Age in Long-Term Partnerships

In the generalized HIV epidemics of sub-Saharan Africa, women account for 57% of people living with HIV, and 88% of women living with HIV worldwide are in Africa (UNAIDS, 2013). Compounding the greater physiological vulnerability of women to HIV, gender inequalities, harmful gender norms, and widespread sexual concurrency mean that African women are at high risk of acquiring HIV within stable relationships (Gouws 2012). HIV negative women in sero-discordant couples have an especially urgent need for better protection. It is recommended that this audience is further segmented by HIV status and age to ensure that interventions are tailored to the different needs and preferences of, for example, (a) an HIV negative woman whose spouse's infidelity puts her at risk, or (b) a young HIV positive woman who want to avoid unintended pregnancy and protect her long-term partner.

Primary Audience 2: Sexually Active Single¹ Women

¹'Single' is used here to denote women who are not in any marital, co-habiting, or other long-term sexual partnership but are nevertheless sexually active, i.e. with short-term and/or casual partners

Gender inequalities such as vulnerability to rape, sex with older men, and unequal access to education and economic opportunities put some women at especially acute risk of HIV infection. This includes girls and adolescents, young women, widows, and divorced women. In comparison to men, girls, adolescents, and younger women are more likely to acquire HIV at an early age, resulting in a global HIV prevalence among girls and young women that is double or greater than among males of the same age (UNAIDS, 2013). WHO reported on World AIDS Day 2013 that more than 2,000,000 adolescents aged 10-19 are living with HIV, and that many do not receive the care and support they need to stay in good health and prevent transmission. Millions more adolescents are at risk of infection (WHO 2013). Data from South Africa (HSRC 2008) illustrates the critical importance of empowering young women to protect themselves while they are still HIV negative: among children under 15, 3% of boys and 2% of girls are HIV positive; by the 15-19 age group, girls are already nearly three times as likely to have become infected (6.7% versus 2.5% of boys); and among 20-24 year olds, four times as many young women are infected (21% versus 5% of young men). HIV prevalence in generalized epidemics typically peaks ten years earlier among women than men (e.g. in South Africa among 20-40 year old women and 30-44 year old men (HSRC, 2008)). These patterns of infection highlight the critical importance of effective HIV prevention strategies that reach young women in inter-generational sexual partnerships.

Primary Audience 3: Male Partners

Although the female condom is a woman-initiated method of protection, men still hold decision-making power in the great majority of sexual partnerships in high HIV prevalence countries. It is critical that sexually active men understand the product in order to create male acceptance and thus more favorable conditions for increasing women's opportunity, ability and motivation to experiment with female condoms and subsequently use them on a regular basis. HIV negative men in sero-discordant couples have a particularly acute need for protection and are likely to be a priority audience of female condom demand creation interventions in high HIV prevalence settings. When both partners are included in female condom programs, both become motivated to use female condoms and are more likely to take up the product (UNFPA, 2011^a).

B – Key populations at risk, in both generalized and concentrated HIV epidemics

Primary Audience 4: Female Sex Workers

Global HIV prevalence among female sex workers is estimated at 12%, increasing to over 30% in settings with medium to high HIV prevalence. Female sex workers are 13.5 times more likely to be living with HIV than all other women, including in high prevalence countries. In sub-Saharan Africa as a whole, HIV prevalence among female sex workers is estimated at 37%. In West Africa, UNAIDS estimates that 10-32% of new HIV infections occur as a result of sex work. 11% of female sex workers in Eastern Europe and 6% of female sex workers in Latin America are estimated to be living with HIV (Kerrigan, 2012).

Although male condom use in commercial sex is relatively high, not all sex workers can negotiate male condom use for a variety of reasons, for example: inexperience, youth, loss of income if the client refuses, non-availability of male condoms, and drunkenness of clients. Female condoms offer sex workers an excellent option with clients and other transactional partners who refuse to or are incapable of using male condoms. Sex workers also have the same need as other women for protection in their personal relationships.

INFLUENCING AUDIENCES

Three influencing audiences are profiled for the purpose of this adaptable strategy: health providers and educators; stakeholders and decision-makers; and journalists. Countries should select and profile influencing audiences based on socio-cultural context. In addition to the three audiences profiled below, other influencers such as politicians, community and religious leaders, celebrities, and local role models may be important to the success of national or sub-national demand generation efforts. Other important influencers typically include users' family members (including parents of young people), users' sexual partners, clients of sex workers and more.

Influencing audience 1: Health Providers and Health Educators

Health facilities, health promotion programs and small businesses (e.g. hair salons or nightclubs) are the principal channels through which female condoms are made available, and many studies point to the critical importance of insertion and negotiation skills training in driving uptake of female condoms. Health service providers and health educators must therefore be at the heart of female condom marketing strategies. Their interest in and beliefs about female condoms will be evident in the HIV prevention or reproductive health interventions that they implement. The extent to which women and their partners are offered female condoms proactively, encouraged to try them, and helped to overcome any difficulties with initial use all depend on health providers and health educators.

Influencing audience 2: Stakeholders and Decision-Makers

For the female condom to be widely adopted, decision-makers and program managers must buy into female condoms as an essential dual protection method for women and view female condom promotion as a good use of human, financial and other resources. Individuals and management / advisory bodies at all levels may have the potential to make or break female condom programs. Demand generation strategies should therefore include thorough, tailored advocacy components.

Influencing audience 3: Journalists

Print, broadcast and online media reach millions of the women and men who could benefit most from access to female condoms. As global

distribution is scaled up, the media will have a critical role to play in bringing the method into target users' everyday awareness. Objective, unbiased reporting of the efficacy, attributes and availability of female condoms can increase target users' receptiveness to promotion efforts. On the other hand, negative or misinformed reporting will hamper demand generation efforts, and an absence of coverage will render the task of awareness-raising much greater. Demand generation strategies should therefore include comprehensive media engagement components, informed to the greatest possible extent by audience-specific evidence on media consumption – both quantitative (what they consume) and qualitative (what they trust).

Audience Profiles

Stages of change is used as a framework for the audience profiles. Because in most contexts existing awareness and use is low, each profile begins at the earliest stage of change, i.e. pre-contemplation. This part of the profile highlights the key touch points on his or her journey – i.e. the experiences that led to progress through each stage of change.

Each profile includes two separate archetypes, designed to show typical barriers to overcome, as well as opportunities for intervention, in order to move audiences through the stages of change. The **'before' archetype** represents the audience being targeted with female condom promotion. As a target audience, there is an assumption that she or he is not already performing the desired behavior. The 'before' archetypes have been constructed using data from the studies cited at the end of each audience profile and/or from information contained in the journal articles cited at the end of each profile. The **'after' archetype** assumes that the demand creation initiative has been successful, and this person is now performing the desired behavior. This section of the profile describes the person's behavior or behavioral intention at each stage of behavior change, as well as key drivers and barriers affecting progress to the next stage. The 'after' archetypes are based on behavioral evidence and programmatic recommendations contained in the sources cited at the end of each profile.

PRIMARY AUDIENCE 1: WOMEN OF REPRODUCTIVE AGE IN LONG-TERM PARTNERSHIPS, IN GENERALIZED HIV EPIDEMICS

Desired Behavior: *Consistent use of either male or female condoms with regular partner*

'Before' Archetype A: PAMELA, 26, office clerk, wife, and

'Before' Archetype B: MARGARET, 29, vendor, wife, and mother,

mother, Zimbabwe – has never used a female condom.

Pamela is 26 and lives with her partner Jackson. They have one young child and plan to marry in a few years and have more children. She takes contraceptive pills to avoid getting pregnant, but has sleepless nights every time she forgets a pill: they could not possibly afford another child at the moment. She and Jackson have never tested for HIV together, and Pamela's last negative test was several years ago. She worries about his other women but cannot challenge him about it, and he has refused to talk about (male) condoms since the early months of their relationship.

'After' Archetype A: PAMELA, consistent female condom user - key touch-points in her journey

Pre-contemplation: She has seen female condoms advertised at her hair salon, but has never considered using one.

Contemplation: Pamela's hair stylist gives her some female condom samples, explains how to use them, and encourages her to practice on a pelvic model. She reassures Pamela that many men like the product once they try it, and advises her to talk to Jackson about her desire to try a different contraceptive method.

Trial: She practices inserting the female condom alone, using the diagram and instructions the hairdresser gave her, before talking to Jackson about it. Although he is wary of its size and shape, he agrees to try it. It takes some time to insert the condom in front of him the first time, but by the third time they use one she is quite confident and comfortable with the product. Pamela stocks up on female condoms next time she visits the salon.

Action: A few weeks later, she talks to Jackson about coming off the pill and using female condoms as their contraceptive, and

Zimbabwe – has never used a female condom.

Margaret was diagnosed with HIV three years ago whilst pregnant with her second child. Her husband Henry was diagnosed at the same time. They are watchful about their health, and neither has need of antiretroviral therapy. She uses an intrauterine device (IUD) to prevent pregnancy and they usually use male condoms to prevent re-infection. However, sometimes Henry does not want to use one and Margaret cannot insist or refuse sex. She is faithful, but she knows he has a side partner and worries about STIs.

'After' Archetype B: MARGARET, regular female condom user - key touch-points in her journey

Pre-contemplation: She has heard of female condoms but has never actually seen one.

Contemplation: Margaret is introduced to female condoms by the nurse at the HIV clinic who suggested it as an alternative to male condoms, gave her some female condoms along with a diagram and instructional leaflet, and helped her try one on a demonstration model. She also advised Margaret on the best way to initiate female condom trial with her husband. She is interested but thinks this condom looks large and complicated.

Trial: She and Henry try a female condom for the first time, after she explains the product, its use, and its efficacy. Although she finds it somewhat awkward to insert the first time, after practicing a few times it becomes easy and feels natural. Henry is open to experimenting, because he also wants an alternative to male condoms, and he enjoys the way sex feels less constricting with a female condom.

Action: Encouraged by their first experience, Margaret initiates female condom use several more times during the following

he agrees to try it for a limited time. Inserting it becomes part of their foreplay, and Jackson agrees that he barely notices it is there during sex. Now that she has an alternative to the pill and the means to protect herself against STI/HIV, Pamela experiences a new peace of mind.

Maintenance: Jackson sees how happy Pamela is and agrees to stick with female condoms as their family planning method. They both believe female condoms are an effective contraceptive if used correctly and consistently. She either buys inexpensive, socially marketed female condoms at the salon or picks them up for free at the health center.

weeks when Henry does not want to use a male condom. She already finds them easy and comfortable to use and can always obtain them at the health center. Margaret is relieved that she no longer has to depend on her husband to use a male condom, and they are both happy to be able to share responsibility for protection.

Maintenance: She now gets a regular supply of female condoms from the clinic, to use whenever she and/or Henry wants an effective alternative to male condoms. As a result, they have far less unprotected sex, meaning that they are both less likely to become re-infected with HIV and that Margaret no longer has to worry about STIs.

Source: Meekers (2005). Factors Associated with Use of the Female Condom in Zimbabwe.

PRIMARY AUDIENCE 2: SINGLE, SEXUALLY ACTIVE WOMEN IN GENERALIZED HIV EPIDEMICS

Desired Behavior: *Consistent use of either male or female condoms with all partners*

'Before' Archetype: *ALICE, 23, student, Lesotho – has never used a female condom*

Alice is training to be a teacher. Whereas a few years ago only a couple of women she knew were HIV positive, now it is happening to many women her age. Alice worries about getting pregnant and the negative impact that having a child would have on her education and career, but needs a contraceptive method that also protects her against STI/HIV infection. Alice enjoys sex but is not interested in a long-term relationship at her age – she wants to marry and have a family eventually, but right now she is more interested in meeting different men and having fun. However, like many of her friends, she often dates older men, usually married men with money to spend on her. She would not consider herself promiscuous – she has only ever had a few one night stands – but she has also had several short-term boyfriends of her own age during the last year. Her same-age partners typically agree to use male condoms, especially the first few times she has sex with them. Her current concern is Moses, - he insists on unprotected sex and because he pays for everything she has no power to negotiate condom use. Men like Moses would simply swap her for another girl if she insisted, and Alice likes the lifestyle that he offers her.

'After' Archetype: *ALICE, regular female condom user - key touch-points in her journey*

Pre-contemplation: She has heard of female condoms but she has never seen one and nobody she knows has ever used one. She has never considered using one. She sees posters advertising female condoms around the university.

Contemplation: She considers female condoms for the first time. Because she remembers the posters, when she sees female condoms being promoted at a campus health fair she stops to watch, experiments with a female condom on a pelvic model, and takes away free samples and instructions. However, she does not yet know where female condoms are available, she is still not sure whether she will be able to insert it, and she wonders whether it would stay in place during sex.

Trial: She tries a sample with her same-age boyfriend to see how it works and feels. She needed the instructions and to practice insertion several times. The second time it is easier, and she likes the feeling of the outer ring against her clitoris during sex. She also likes that female condoms offer her dual protection, and that she has more control than with male condoms.

Action: She uses female condoms several more times, and would like to use them more often because they protect her against STI/HIV infection. She now knows where they are available, and after the first few uses, she had no problem with insertion. She has the skills and confidence to initiate female condom use with new and same-age partners. Moses refuses to try them, but a few weeks later she ditches him for another older man anyway.

Maintenance: She now uses female condoms whenever she is with a man who does not want to use a male condom, so she always knows that she is protected. She likes the way the female condom molds to her body, and men say they can hardly feel it during sex. With encouragement from friends who also use female condoms, she insisted on using a female condom the first time she had sex with her older boyfriend, and he has not objected since. The stores on campus sell female condoms at a low price, and if she needs to, she can also obtain them for free at the student clinic.

Source: Formative Research Study: Female Condom Pilot Project for Young Women Attending Institutions of Higher Learning in Lesotho, PSI Lesotho 2011

PRIMARY AUDIENCE 3: MALE PARTNERS IN GENERALIZED HIV EPIDEMICS

Desired Behavior: *Consistent use of either male or female condoms with all partners*

'Before' Archetype: *STEPHEN, 24, engineering student, South Africa – has never used a female condom*

Stephen has been dating Mpho for three months; he thinks he is falling in love with her. However, they have reached the difficult relationship stage where both feel they should have become 'trusted partners' but neither has been faithful, and neither trusts the other to be faithful in future. Recently they have had unprotected sex several times when Stephen did not have a condom with him. Stephen is HIV

negative but does not know Mpho's status. Although he enjoys sex more without a condom, he wants to protect his health. He cannot talk to Mpho about all this without upsetting her.

'After' Archetype: STEPHEN, occasional female condom user – key touch-points in his journey

□ **Pre-contemplation:** Stephen has never heard of a female condom; he has no awareness that the product exists.

Contemplation: He and Mpho receive female condoms and related information at a campus health fair. She wants to try the method, but when he sees how big it is he is alarmed. He worries that it will be painful for her to use and cannot see how it will stay in place during sex. The first few times Mpho suggests using one he refuses and uses a male condom instead.

□ **Trial:** A couple of weeks later, after Mpho convinces him with a picture of how the female condom fits inside her body, they use one for the first time. He agrees because he wants to please her and because he is curious to see how the female condom compares to male condoms. He has to wait some minutes while she goes to the bathroom to insert it, and he makes very sure he is inside it properly. After that, however, he feels completely unconstrained by it during sex.

□ **Action:** After a few uses, Mpho is confident enough with the female condom to insert and remove it in front of him. She acquires more female condoms and they use them several times during the next month as an alternative to male condoms. He is more confident in its efficacy now he understands how it works, and when he handled a female condom himself, he noticed how strong it felt. However, when he sees that Mpho is as proficient using female condoms as he is with male condoms he feels threatened and avoids female condoms for a couple of weeks by always ensuring he has a male condom to hand. The next time they use female condoms, the habit sticks. He realizes that the choice of condoms and Mpho's proficiency with female condoms are healthy developments in their relationship.

□ **Maintenance:** Now they always use either male or female condoms, meaning that they are no longer having unprotected sex. Mpho usually carries a female condom in her bag. She can always get them from the campus clinic or buy them at the store. Although Stephen would rather use male condoms most of the time, he has no objection to using female condoms as an alternative. He likes the way the female condom feels during sex, and he is happy that can share responsibility for protection against STI/HIV infection and pregnancy.

Source: "It's a Different Condom, Let's See How It Works": Young Men's Reactions to and Experiences of Female Condom Use During an Intervention Trial in South Africa, Tsitsi et al, 2013

PRIMARY AUDIENCE 4: FEMALE SEX WORKERS IN BOTH GENERALIZED OR CONCENTRATED HIV EPIDEMICS

Desired Behavior: *Consistent use of either male or female condoms with all clients and in personal relationships*

'Before' Archetype: *LILA, 27, sex worker, Nicaragua – has never used a female condom*

Lila has worked in Managua's sex industry since she was 19. She has little education and no other job on which to raise her three children, and no husband. Although she gets regular contraceptive injections to avoid unintended pregnancy, she worries about getting HIV and other STIs from men – including regular clients and her boyfriend – who will not use condoms. She feels powerless to protect herself because she is afraid that clients will leave or become aggressive, and she dare not argue with her boyfriend. Sometimes male condoms do not have enough lubrication, and this causes irritation, making it painful to work.

'After' Archetype: *LILA, regular female condom user – key touch-points in her journey*

Pre-contemplation: She is not interested in female condoms, because she has heard that they are difficult and uncomfortable to use.

Contemplation: Lila's roommate, who uses female condoms, convinces her to go to an educational session run by an NGO HIV prevention program in the barrio where she works. A health promoter shows them the product, shows them how it works on a pelvic model, and gives them a chance to practice inserting condoms on the model. However, she is still intimidated by the female condom's internal ring, and she is afraid that this new device might scare clients away. She also worries about hiding the large package from her children.

Trial: She tries the female condom to see whether she can insert it, because she wants an alternative when men refuse to use condoms – she is afraid of getting an STI and being unable to work. Inserting it is difficult, even following pictorial instructions. She has to persist in order to insert the female condom properly and so that it is comfortable inside her, and she needs to practice several more times before she is confident enough to suggest it to a client.

Action: She initiates female condom use with her next few clients who refuse to use male condoms. Once she got used to the method, she had no problem inserting it, she finds it comfortable to wear, and she can obtain female condoms from the same NGO. Clients who already knew about female condoms are happy to have an alternative to male condoms, but others are uneasy. As the promoter advised her, she always inserts and removes it in front of the client. She quickly realizes how useful female condoms are with clients who are too drunk or in too much of a hurry to use a male condom.

Maintenance: Lila now uses female condoms regularly as an alternative to male condoms. The NGO program ensures a regular supply, and she always tries to have them to hand to protect herself. She likes the female condom because it is well lubricated, strong, and big enough for any client, and because her clients can hardly feel it. Most importantly, because she has more control over its use, she feels empowered to protect herself against STI/HIV infection.

Source: Introducing Female Condoms to Female Sex Workers In Central America, Mack et al, 2010

INFLUENCING AUDIENCE 1: HEALTH PROVIDERS AND HEALTH EDUCATORS

Desired Behavior: *Consistent and proactive promotion of female condoms to all potential beneficiaries*

'Before' Archetype: *JOSEPHINE, 35, nurse, wife, and mother, Malawi – unenthusiastic about female condoms*

Josephine has been a family planning nurse for ten years. She works at a neighborhood clinic in the provincial town where she grew up. Every day, Josephine works amid the suffering that HIV causes for families, and she has personally lost many loved ones to AIDS. For the last few years, provider-initiated counseling and testing for HIV has been part of her job, and it is hard. She has had little training, and every woman she has counseled who contracted HIV from a cheating husband has affected her deeply. She thanks God for a faithful husband and prays that her children can stay safe as they grow up. Now NGOs are coming to her to talk about female condoms again. She remembers female condoms from when she first qualified: impossible to promote because nobody liked them, they were so ugly and difficult to use. Josephine also understands how things work between men and women in her community – when it comes to sex men make all the decisions. She feels trying to persuade couples to use the female condom is futile, and she already has too many important demands on her time. She knows that male condoms are effective, are much cheaper, have always been available, and people know how to use them, so Josephine expects female condoms to fail again this time around.

'After' Archetype: *JOSEPHINE, proactive female condom promoter – key touch-points in her journey*

Pre-contemplation: She is resistant to promoting female condoms. She thinks talking to women or couples about female condoms will be a waste of time. When they were tried before uptake was low, and she cannot imagine how any woman whose partner will

□ not use a male condom could be persuaded to use a female condom – to Josephine the key issues are the same.

□ **Contemplation:** She attends a training session on female condom promotion, where she is also supplied with product, diagrams,

instructional leaflets and a pelvic demonstration model. She is less skeptical after the training; the trainer seemed to understand their reluctance and she answered questions patiently. She was an enthusiastic female condom user herself, talked about her experience with them, and encouraged the nurses and outreach workers to try for themselves. However, Josephine remains doubtful about the female condom as a feasible alternative to male condoms. She still believes that trying to promote female condoms will take time she simply does not have, and that clients will not be receptive.

Trial: Using job aids she received as part of the training, she begins to talk about female condoms, grudgingly at first, and mostly during post-test HIV counseling as an option for positive women and positive concordant or HIV discordant couples. She gains confidence in the product information and key messages, as well as with the model, and talking about the female condom only takes a few minutes with each client. She is also encouraged by some of the reactions she receives – her early clients confirm that, after practicing a few times, the female condom is easy and comfortable to use, and that their partners hardly feel it during sex.

Action: Josephine increases the range of clients to whom she promotes the female condom and actively encourages them to return for follow-up visits. Because she has the important information and key messages at her fingertips, a pelvic model to demonstrate on, and instructions to give out with the condoms, integrating their promotion into her work is not as time-consuming as she had feared. As more clients take them away, she gains belief and confidence in promoting them. Team meetings where she can discuss difficulties, supportive supervision, and positive feedback from clients (both male and female) all increase her competency, confidence and motivation.

Maintenance: Female condoms are now an integral part of her HIV and family planning counseling. They do not work for everybody, but each time a woman or couple asks for more, Josephine knows she has made a difference to their lives and helped to prevent HIV transmission in her community. Commodities and educational materials have been supplied consistently. She is now convinced that the government is committed to female condoms for the long haul this time around, and she is committed to promoting them.

Sources: Women in the Time of AIDS: Barriers, Bargains, and Benefits, Mantell et al, 2008; Access, Frost & Reich, 2009

INFLUENCING AUDIENCE 2: STAKEHOLDERS AND DECISION-MAKERS

Desired Behavior: *Proactive short- and long-term championing of female condom programs*

'Before' Archetype: *DR. KANJA, 44, district health director, husband, and father, Mozambique*

Dr. Kanja has worked his way up from a village health center to the job he takes such pride in today. With 15% of people in his district living with HIV, two of his brothers lost to AIDS-related illnesses, and two sexually active daughters, Dr. Kanja is passionate about HIV prevention. He knows how men of all ages can be – he was less wise in his younger days – but is now proudly faithful to his wife and considers himself an advocate of progress in issues relating to gender equality. Dr. Kanja recently received word that the Ministry of Health is renewing efforts to promote the female condom. Mainly, he is skeptical about the extent to which this is MOH’s initiative or whether the donors are pulling strings again. As a father, Dr. Kanja understands the appeal of female condoms, although he certainly cannot imagine using one. However, he also worries that women in the district health management team and the hospitals will get carried away with unrealistic expectations. He is concerned that a drive for female condoms may distract resources from important HIV prevention interventions like treatment adherence programs, male condom distribution and medical male circumcision. He also questions whether the cost of female condoms compared to male condoms can really be justified. He also knows how most of his colleagues / staff think about female condoms: they do not see the point of them, let alone the appeal. This being the case, Dr. Kanja simply does not have the time it would take to motivate them when there are so many other priorities; anyway, this new interest in female condoms will go away once the money runs out.

‘After’ Archetype: DR. KANJA, female condom champion – key touch-points in his journey

Pre-contemplation: He is resistant to promoting female condoms. He does not have the time or resources to promote female condoms, and he doubts that the government’s interest in them will last long.

Contemplation: He meets a female condom master trainer at a meeting in the provincial capital. He is impressed with her passion and level-headedness, and she convinces him that the new ‘strategy’ for promoting female condoms will be backed up by commitment, resources, and effective action.

Trial: He attends a subsequent orientation workshop himself, before leaving a senior nurse, Joyce, behind for in-depth training. He is impressed again when she returns armed with condoms, job aids, posters, anatomical diagrams, instructional brochures and DVDs, and enough pelvic models for every clinic in the district. Importantly, she also has a sensible action plan and plenty of motivation to implement it, meaning that he does not personally have to divert a lot of time and energy to this initiative. He therefore supports Joyce to hold a district training workshop, where discussion confirms that many women in the district could benefit from female condoms and his staff create an action plan for integrating female condom promotion into HIV, STI and family planning counseling at minimal cost.

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Action: Within six months, female condoms are available at every clinic in the district and at least one nurse in each clinic has been trained in promotion. Although initial uptake is slow, he rewards the team's early efforts with a workshop so they can share experiences and ideas and receive more training, including training as trainers. They commit as a team to giving female condoms a chance, and Dr. Kanja includes female condom skills in his annual training plans for primary healthcare nurses, HIV peer educators and community health workers. Over the next couple of years as distribution rises, he receives a reliable supply of commodities and educational materials. The feedback he hears from his staff and women in the community is positive.

Maintenance: Two years later, Dr. Kanja's district has one of the highest per capita female condom distribution rates in the country. The district has never stocked out of female condoms and its *overall* condom distribution figure (for male and female condoms) has increased by nearly 20%. Furthermore, the creation of access to and demand for female condoms has been achieved with existing resources, with minimal extra burden on Dr. Kanja and his team. Female condoms are now an integral part of the district's HIV prevention and family health promotion efforts, and he is delighted that the government is committed to the product for the long haul this time around: in a job that is a constant struggle against a multitude of severe health threats, female condoms have been a small but tangible victory.

Sources: Women in the Time of AIDS: Barriers, bargains, and benefits, Mantell et al, 2008; Access, Frost & Reich, 2009

INFLUENCING AUDIENCE 3: JOURNALISTS

Desired Behavior: *Unbiased awareness-raising about female condoms; coverage of program initiatives and achievements*

'Before' Archetype: *ALISHA, 30, radio talk-show host, Botswana – detractor of female condoms*

Alisha hosts a week-day radio show aimed at women, which includes music, studio guests and call-in discussions that are usually about women's issues, gender relations, and relationships. She regularly attends government and other briefings / workshops on women's issues, and over the years she has been involved in several life-skills initiatives for adolescent girls, young women and women living in poverty.

'After' Archetype: *ALISHA, friend of the female condom – key points in her journey*

Pre-contemplation: She has no interest in female condoms. She knows what they look like and cannot imagine any woman wanting to use one.

Contemplation: Alisha attends a media workshop on gender and HIV, where a whole hour is given over to talk of female condoms.

Apparently Global Female Condom Day is coming up, so she checks her email while government and NGO speakers talk about why they are important. To her horror, participants are then presented with packaged female condoms and anatomical models and asked to try the product out. Two days later, a Ministry of Health official calls her personally to ask her to be part of Global Female Condom Day.

Trial: To test her listeners' receptiveness, she simply announces that September 16 2013 will be Global Female Condom Day, asks them to text in their thoughts, and reads out the most positive and funniest negative messages on air. The quantity of positive responses genuinely surprises her, as does the senders' enthusiasm for this product. She reads through the media pack on female condoms that she was given at the workshop but gives no thought to trying the product samples. When she is approached again and offered studio guests who can talk about female condoms and answer questions about them on September 16 she agrees, with misgivings.

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Action: The September 16 show is a success. The two speakers (a man and a woman) are passionate, entertaining, and unafraid to talk about how a female condom feels in the vagina, or against the clitoris, or against the penis. Her female guest talks honestly (and comically) about her own first experience trying to insert a female condom, but stresses that after the first couple of times it was very easy. Alisha finds herself becoming engaged in the discussion and even encouraging her listeners to ask about female condoms the next time they go to the health center.

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Maintenance: Over the next few months she responds to several more requests to promote female condoms on her show. Although she still has not used one herself, she now understands the undeniable benefits that female condoms can offer all kinds of women, and she has encouraged the women's empowerment program she works with to include female condom skills training in their activities.