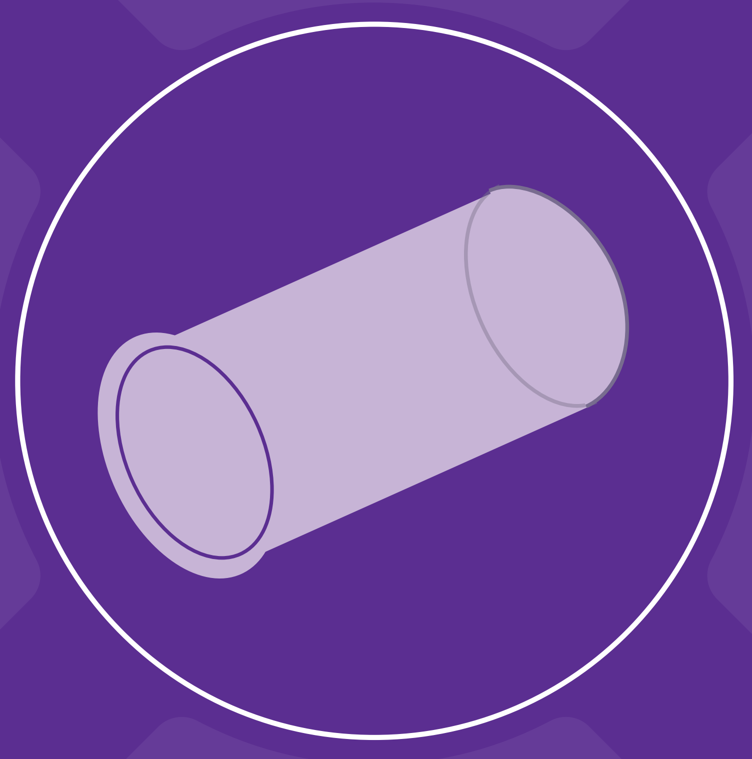
Demand Generation for Reproductive, Maternal, Newborn and Child Health Commodities

AN ADAPTABLE COMMUNICATION STRATEGY FOR FEMALE CONDOMS

JULY 2014



Acknowledgements

The USAID-funded Health Communication Capacity Collaborative (HC3)—based at the Johns Hopkins Center for Communication Programs (CCP) within the Johns Hopkins Bloomberg School of Public Health—would like to acknowledge Diana Gourvenec (independent consultant) for authoring this strategy with contributions from Bidia Desperthes (UNFPA), Clancy Broxton (USAID), Beth Skorochod (PSI), Risha Hess (PSI), Kimberley Whipkey (PATH), Saskia Husken (Universal Access to Female Condoms – UAFC), Ciska Kuijper (UAFC) Mags Beksinska (University of the Witwatersrand), Lucie Van Mens (The Female Health Company), Joanna Skinner (CCP), Kate McCracken (CCP) and Erin Portillo (CCP). HC3 thanks Kathleen Fox, Kim Martin, Katie Kuehn and Mark Beisser for their editing and layout support. HC3 would also like to thank Zarnaz Fouladi, Hope Hempstone and Stephanie Levy at USAID for their invaluable feedback, guidance and support.

Suggested citation:

The Health Communication Capacity Collaborative HC3. (2014). *An adaptable communication strategy for female condoms*. Baltimore: Johns Hopkins Bloomberg School of Public Health Center for Communication Programs.

The Demand Generation for Reproductive, Maternal, Newborn and Child Health Commodities activities are implemented by the Health Communication Capacity Collaborative (HC3) at Johns Hopkins Center for Communication Programs (CCP), with support from the RMNCH Trust Fund and the United States Agency for International Development (USAID), in partnership with Demand Generation sub-group of the UNCoLSC Demand, Access and Performance Technical Resource Team, including Population Services International (PSI), International Consortium on Emergency Contraception (ICEC), Jhpiego and other partners.

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Table of Contents

Acronyms 4

Introduction 5
- Aim 6
- Intended User 6
- What is a Communication Strategy? 6
- How to Use this Adaptable Communication Strategy 6
- Thirteen Lifesaving Commodities for Women and Children 6

Demand Generation: An Overview 9
- What is Demand Generation? 10
- Who are the Audiences of Demand Generation Programs for the 13 Lifesaving Commodities? 10
- Key Concepts and Definitions in Demand Generation 11
- Conceptual Framework 12

Adaptable Communication Strategy: Structure and Guidance 13
- Step 1: Analyze the Situation 14
- Step 2: Define a Vision 17
- Step 3: Choose the Intended Audiences 18
- Step 4: Design Message Strategy (Objectives, Positioning, Key Messages) 19
- Step 5: Determine Activities and Interventions 20
- Step 6: Plan for Monitoring and Evaluation 22

An Illustrative Communication Strategy for Female Condoms 25
- Step 1: Analyze the Situation 26
- Step 2: Define a Vision 35
- Step 3: Choose the Intended Audiences 36
- Step 4: Design Message Strategy 46
- Step 5: Determine Activities and Interventions 51
- Step 6: Plan for Monitoring and Evaluation 57

References 59

Contacts 63

Acronyms

CBO	Community-based organization
CCP	Johns Hopkins Center for Communication Programs
CE	Contraceptive eligibility
DHS	Demographic and Health Surveys
EE	Entertainment education
EWEC	Every Woman Every Child
HC3	Health Communication Capacity Collaborative
ICT	Information and communication technology
IPC	Interpersonal communication
IUD	Intrauterine device
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NGO	Non-governmental organization
PLWH	People living with HIV
PPP	Public-private partnership
RMNCH	Reproductive, maternal, newborn and child health
SBCC	Social and behavior change communication
SM	Social marketing
SMS	Short message service
STI	Sexually transmitted infection
UAFC	Universal Access to Female Condoms Joint Programme
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCoLSC	United Nations Commission on Lifesaving Commodities for Women and Children
UNGASS	United Nations General Assembly Special Sessions
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USFDA	U.S. Food and Drug Administration
WHO	World Health Organization
WRA	Women of reproductive age

Introduction

Aim

To provide step-by-step guidance and illustrative content in creating a communication strategy to generate demand for **female condoms**.

Intended User

This Adaptable Communication Strategy (the Strategy) is designed to be useful to multiple audiences, including staff from ministries of health, non-governmental organizations (NGOs) and community-based organizations (CBOs). The Strategy can support the efforts of communication professionals working directly on behavior change communication programs, as well as other professionals working in reproductive, maternal, newborn and child health (RMNCH) who need to create a demand generation component to support program activities.

What is a Communication Strategy?

A communication strategy provides a "road map" for local action targeted at behavior change and creates a consistent voice for the messages, materials and activities developed. It also ensures that activities and products work together to achieve the program goal and objectives. The final communication strategy should be used to guide content development of program materials, such as advocacy briefs, client leaflets, and job aides and tools for health providers, thereby ensuring consistent positioning and messaging across all activities.

The communication strategy, however, is not a static product. It must be responsive to an ever-changing environment. Adaptations may be necessary in order to respond to new research findings and data, unexpected events, changing priorities or unforeseen results. Communication strategies are essential in addressing priority or emergent health issues and allow for harmonization of priorities, approaches and messages among all the relevant organizations and stakeholders.

How to Use this Adaptable Communication Strategy

This Strategy forms part of a comprehensive Demand Generation Implementation Kit for Underutilized, Lifesaving Commodities (the I-Kit) (http://sbccimplementationkits.org/demandrmnch). The I-Kit includes commodity-specific communication strategies designed to be easily adapted across multiple country contexts and integrated into existing RMNCH plans. The I-Kit also includes resources on four core cross-cutting demand generation areas: addressing the role of gender, a theory-based framework for media selection, utilizing information and communication technologies (ICTs) and new media, and leveraging public-private partnerships (PPPs).

This Strategy is not intended to serve as a "one-size-fits-all" model. It is designed as a quick-start foundation based on available evidence to provide guidance in answering the following questions:

- Where are we now?
- What is our vision?
- How are we going to achieve our vision?
- How do we know we achieved our vision?

Ideally, country-level teams would then integrate commodity-specific content tailored to the country context into existing or new RMNCH communication strategies for demand generation.

It is important to note that the strategy focuses on communication—typically, the product promotion component of a social marketing (SM) approach. If desired, the strategy can be integrated and expanded into a broader social marketing framework, addressing product, price and place.

Thirteen Lifesaving Commodities for Women and Children

In 2010, the United Nations (UN) Secretary-General's *Global Strategy for Women's and Children's Health* (the Global Strategy) highlighted the impact that a lack of access to lifesaving commodities has on

the health of women and children around the world. The Global Strategy called on the global community to save 16 million lives by 2015 by increasing access to and appropriate use of essential medicines, medical devices and health supplies that effectively address the leading avoidable causes of death during pregnancy, childbirth and childhood. Under the Every Woman Every Child (EWEC) movement, and in support of the Global Strategy and the Millennium Development Goals (MDGs) 4 and 5, the United Nations Commission on Life Saving Commodities (UNCoLSC) for Women and Children (the Commission) was formed in 2012 to catalyze and accelerate reduction in mortality rates of both women and children. The Commission identified 13 overlooked lifesaving commodities across the RMNCH "Continuum of Care" that, if more widely accessed and properly used, could save the lives of more than six million[1] women and children. For additional background information on the Commission, please refer to http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities.

[1]For assumptions used to estimate lives saved see UNCoLSC Commissioner's report (annex) (http://www.everywomaneverychild.org/images/UN_Commission_Report_September_2012_Final.pdf)

Figure 1: 13 Lifesaving Commodities

Reproductive Health

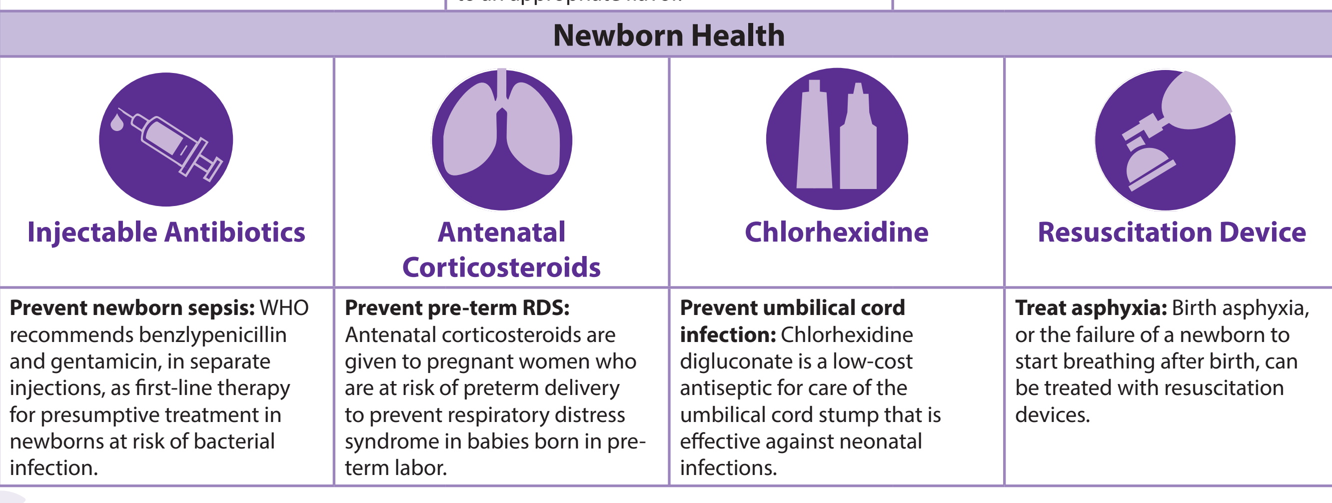
Female Condoms	Contraceptive Implants	Emergency Contraception
Prevent HIV and unintended pregnancy: A female condom (FC) is a plastic pouch made of polyurethane that covers the cervix, vagina and part of the external genitals. FCs provide dual protection by preventing STI, including HIV, and unintended pregnancies.	**Prevent unintended pregnancy:** Contraceptive implants are small, thin, flexible plastic rods inserted into a woman's arm that release a progestin hormone into the body. These safe, highly effective, and quickly reversible contraceptives prevent pregnancy for three to five years.	**Prevent unintended pregnancy:** The emergency contraceptive pill is the most widely available emergency contraceptive in developing countries. It is optimally taken in one dose of 1.5mg as soon as possible after sexual activity. An alternative product of 0.75mg is also widely available.

Maternal Health

Oxytocin	Misoprostol	Magnesium Sulfate
Post-partum hemorrhage: WHO recommends oxytocin as the uterotonic of choice for prevention and management of postpartum hemorrhage.	**Post-partum hemorrhage:** In settings where skilled birth attendants are not present and oxytocin is unavailable, misoprostol (600 micrograms orally) is recommended.	**Eclampsia and severe pre-eclampsia:** WHO recommends MgSO4 as the most effective treatment for women with eclampsia and severe pre-eclampsia.

Child Health

Amoxicillin	Oral Rehydration Salts	Zinc
Pneumonia: Amoxicillin is an antibiotic that is used to treat pneumonia in children under five. Amoxicillin is prepared in 250mg scored, dispersible tablet (DT) in a blister pack of 10 DTs.	**Diarrhea:** Oral rehydration salts (ORS) is a glucose-electrolyte solution given orally to prevent dehydration from diarrhea. ORS is packaged in sachets of powder to be diluted in 200 ml, 500 ml or 1 liter of fluid, prepared to an appropriate flavor.	**Diarrhea:** Replenishment with zinc can reduce the duration and severity of diarrheal episodes. Zinc is prepared either in 20mg scored, taste masked, dispersible tablets or oral solutions at concentration of 10mg/5ml.



Newborn Health

Injectable Antibiotics	Antenatal Corticosteroids	Chlorhexidine	Resuscitation Device
Prevent newborn sepsis: WHO recommends benzlypenicillin and gentamicin, in separate injections, as first-line therapy for presumptive treatment in newborns at risk of bacterial infection.	**Prevent pre-term RDS:** Antenatal corticosteroids are given to pregnant women who are at risk of preterm delivery to prevent respiratory distress syndrome in babies born in pre-term labor.	**Prevent umbilical cord infection:** Chlorhexidine digluconate is a low-cost antiseptic for care of the umbilical cord stump that is effective against neonatal infections.	**Treat asphyxia:** Birth asphyxia, or the failure of a newborn to start breathing after birth, can be treated with resuscitation devices.

Demand Generation: An Overview

What is Demand Generation?

Demand generation increases awareness of and demand for health products or services among an intended audience through social and behavior change communication (SBCC) and SM techniques. Demand generation can occur in three ways:

- **Creating new users–**convincing members of the intended audience to adopt new behaviors, products or services.
- **Increasing demand among existing users–** convincing current users to increase or sustain the practice of the promoted behavior and/or to increase or sustain the use of promoted products or services.
- **Taking market share from competing behaviors** (e.g., convincing caregivers to seek health care immediately, instead of not seeking care until their health situation has severely deteriorated or has been compromised) and products or services (e.g., convincing caregivers to use oral rehydration salts (ORS) and zinc instead of other anti-diarrheal medicines).

When well designed and implemented, demand generation programs can help countries reach the goal of increased utilization of the commodities by:

- Creating informed and voluntary demand for health commodities and services.
- Helping health care providers and clients interact with each other in an effective manner.
- Shifting social and cultural norms that can influence individual and collective behavior related to commodity uptake.
- Encouraging correct and appropriate use of commodities by individuals and service providers alike.

In order to be most effective, demand generation efforts should be matched with efforts to improve logistics and expand services, increase access to commodities, and train and equip providers, in order to meet increased demand for products and/or services. Without these simultaneous improvements, the intended audience may become discouraged and demand could then decrease. Therefore, it is highly advisable to coordinate and collaborate with appropriate partners when forming demand generation communication strategies and programs.

Who are the Audiences of Demand Generation Programs for the 13 Lifesaving Commodities?

Reducing maternal and child morbidity and mortality through increased demand for and use of RMNCH commodities depends on the collaboration of households, communities and societies, including mothers, fathers and other family members, community- and facility-based health workers, leaders and policy makers. Some of the commodities are more provider-focused in terms of demand and utilization, but all depend on the care-seeking behaviors of women and families.

Figure 2: Audiences of Demand Generation

Provider-focused	Provider and End-user
☐ Oxytocin	☐ Female condoms
☐ Magnesium sulfate	☐ Implants
☐ Injectable antibiotics	☐ Emergency contraception
☐ Antenatal corticosteroids	☐ Misoprostol
☐ Resuscitation equipment	☐ Chlorhexidine
☐ Amoxicillin	☐ ORS
	☐ Zinc

Care-seeking by women and families

Key Concepts and Definitions in Demand Generation

Social and Behavior Change Communication (SBCC). SBCC promotes and facilitates behavior change and supports broader social change for the purpose of improving health outcomes. SBCC is guided by a comprehensive ecological theory that incorporates both individual-level change and change at the family, community, environmental and structural levels. A strategic SBCC approach follows a systematic process to analyze a problem in order to define key barriers and motivators to change, and then design and implement a comprehensive set of interventions to support and encourage positive behaviors. A communication strategy provides the guiding design for SBCC campaigns and interventions, ensuring communication objectives are set, intended audiences are identified and consistent messages are determined for all materials and activities.

Social Marketing (SM). SM seeks to develop and integrate marketing concepts (product, price, place and promotion) with other approaches to influence behaviors that benefit individuals and communities for the greater social good. (http://socialmarketing.blogs.com/r_craiig_lefebvres_social/2013/10/a-consensus-definition-of-social-marketing.html)

Channels and Approaches

Advocacy. Advocacy processes operate at the political, social and individual levels and work to mobilize resources and political and social commitment for social and/or policy change. Advocacy aims to create an enabling environment to encourage equitable resource allocation and to remove barriers to policy implementation.

Community Mobilization. Community mobilization is a capacity-building process through which individuals, groups or organizations design, conduct and evaluate activities on a participatory and sustained basis. Successful community mobilization works to solve problems at the community level by increasing the ability of communities to successfully identify and address their needs.

Entertainment Education (EE). EE is a research-based communication process or strategy of deliberately designing and implementing entertaining educational programs that capture audience attention in order to increase knowledge about a social issue, create favorable attitudes, shift social norms and change behavior.

Information and Communication Technologies (ICTs). ICTs refer to electronic and digital technologies that enable communication and promote the interactive exchange of information. ICTs are a type of media, which include mobile and smart phones, short message service (SMS) and social media, such as Facebook and Twitter.

Interpersonal Communication (IPC). IPC is based on one-to-one communication, including, for example, parent-child communication, peer-to-peer communication, counselor-client communication, or communication with a community or religious leader.

Mass and Traditional Media. Mass media reaches audiences through radio, television and newspaper formats. Traditional media is usually implemented within community settings and includes drama, puppet shows, music and dance. Media campaigns that follow the principles of effective campaign design and are well executed can have a significant effect on health knowledge, beliefs, attitudes and behaviors.

Conceptual Framework

This strategy uses stages of change theory of behavior change as a guiding framework. The stages of change theory suggests that audiences will pass through various stages as they adopt a new behavior—e.g., female condom use. Because the intended audiences for demand generation for female condoms are relatively homogenous—in terms of their familiarity with the product or lack thereof—this theory was selected because it is a conceptual framework that supports more long-term strategic thinking (as opposed to short-term campaign planning, for example). A multi-stage behavior change framework is also appropriate to this commodity because new users must be motivated to acquire the skills required to try female condoms and use them successfully. The five stages are listed below, along with common barriers to use that a new female condom user is likely to experience at each stage:

- **Pre-contemplation—**She may lack personal risk perception, she may not have heard of female condoms or she may be uninterested in them. She will need information that helps her to become aware of female condoms and how she could benefit from using them.
- **Contemplation—**She may believe in certain myths about female condoms and she is focused on barriers to use. Access, skills training and support from influencers or role models may all help to interest her in trying the product.
- **Preparation/Trial—**The first one to three times she tries female condoms are critical points in her journey; discouragement or bad experiences may put her off or set her back. It is essential that she is supported (e.g., with skills training) through positive first experiences that give her confidence and that she believes she can have reliable access to female condoms in the future.
- **Action—**By this stage, she wants to use female condoms. However, barriers to continued use may include access and affordability. To become a regular user, she will need a reliable female condom outlet or outlets, as well as a source of support for any problems she encounters.
- **Maintenance—**She has now made female condom use a part of her life, but problems, such as access and cost, could still cause her to cease using the method.

As well as moving intended users through the stages of change, interventions must actively prevent relapse, which can occur at any stage in a new user's journey; for example, a woman who wants to make the female condom her main contraceptive method (Action stage) could lose confidence in the program entirely if her local clinic stocks out of the product (i.e. relapse to pre-contemplation stage). Programmers must also avoid trying to move intended audiences too quickly from one stage to the next or even make them skip certain stages altogether. For example, sex workers who have never been sensitized about the benefits of female condoms or trained to use them are unlikely to be motivated to try them by point-of-sale promotion or messages focused on product availability.

Furthermore, a sex worker who may choose to try the female condom with no prior knowledge or information based on such advertising (i.e. moved straight from Pre-contemplation to Action), without passing through the Contemplation and Preparation stages, could potentially have a negative experience because she does not know (1) how to use the product correctly or (2) how to effectively explain the female condom to her client (who may also have no knowledge or experience with female condoms).

Adaptable Communication Strategy: Structure and Guidance

This strategy presents a six-step process to guide country-level adaptation based on local situation analysis and formative research:

Step	
Step 1	Analyze the Situation
Step 2	Define a Vision
Step 3	Choose Intended Audiences
Step 4	Select Key Messages
Step 5	Determine Activities and Interventions
Step 6	Plan for Monitoring and Evaluation

Explanations of each step begin below. Illustrative content for each step is provided in the following section.

Who Should Be Involved in Strategy Development?

Developing a communication strategy typically involves convening a group of stakeholders—ideally including representatives of the government, health area experts, marketing or communication specialists, and members of intended audiences—to review existing data, identify key audiences, and develop messaging and appropriate communication channels. Other potential partners may include private sector representatives for the formation of public-private partnerships, which can be used to strengthen a demand generation program, based on the needs and opportunities within an individual country context.

Step 1: Analyze the Situation

What is a situation analysis?
The situation analysis focuses on gaining a deeper understanding of the challenges and barriers to address within a specific context that influence the current demand and utilization of a priority RMNCH commodity, including those affected and their perceived needs; social and cultural norms; potential constraints on and facilitators for individual and collective change; and media access and use by the intended audiences. It also examines the status of the lifesaving commodity, including relevant policies, regulations, manufacturing, prices, supply chains, availability, level of knowledge (provider and end user) and level of use (provider and end user). In short, the situation analysis answers the question: "Where are we now?"

The situation analysis should also examine the attitudes, values, interests, aspirations and lifestyle of the intended audiences. This information, called psychographics, allows for a better understanding of what motivates and what hinders the intended audiences' decisions and actions. Psychographics provide character sketches of the intended audiences that go beyond demographic information (sex, age, education, parity, etc.) and help to build a fuller picture of the audiences as individuals and how they may be nested within and influenced by their community.

Why conduct a situation analysis?
A comprehensive situation analysis is essential as it provides a detailed picture of the current state of the commodity, needs and barriers which will direct the design and implementation decisions of the strategy and ultimately affect the level of success in generating demand and use.

How to conduct a situation analysis
As noted above, conducting a situation analysis typically involves convening a group of stakeholders and reviewing existing data in order to identify key information. A global synthesis of evidence conducted for each of the 13 underutilized commodities can provide a global view of available information and lessons learned from other country contexts (available at http://sbccimplementationkits.org/demandrmnch/evidence-synthesis). Additional sources of country-specific secondary data may include Demographic and Health Surveys (DHS) (http://www.measuredhs.com/), Multiple Indicator Cluster Surveys (MICS) (http://www.unicef.org/statistics/index_24302.html), quantitative and qualitative research conducted by NGOs, or private sector market research, where available, such as Nielsen (http://www.nielsen.com/us/en.html). RMNCH policies and guidelines also may assist in analyzing the situation.

If existing data, particularly on social and behavioral drivers and psychographics, is not sufficient, is outdated or does not provide enough insight into priority audiences, it may be necessary to conduct additional primary formative research in the form of focus groups, interviews or informal visits to communities and homes. For all provider audiences, it may be especially important to conduct formative research around provider attitudes and other drivers to provider behavior. Similarly, for all audiences (providers and end users), it may be especially important to conduct formative research to develop realistic psychographics.

What are the key questions?

The situation analysis has two main sections:
- Health and Commodity Context
- Audience and Communication Analysis

Health and Commodity Context
Below is an example of a set of questions to consider when analyzing the health and commodity-specific context relevant to female condoms:

HIV
- What is the HIV prevalence and incidence? What gaps exist in the data and what are the plans to gather that information?
- Which segments of the female population are most affected by HIV?
- What trends can be observed in HIV prevalence and incidence among women of reproductive age (WRA) during the past 10 years? Among which female population segments have HIV incidence and prevalence increased, declined or remained static?

Reproductive Health
- What are the maternal/neonatal/child mortality rates? What gaps exist in the data and what are the plans to gather that information?
- What is the contraceptive prevalence rate, disaggregated by age group, geographic location, etc.?
- What is the estimated unmet need for contraceptives?
- What patterns exist in contraceptive uptake over the past 5–10 years? In what ways has contraceptive use increased, declined or remained static?

Commodity
- What proportion of women, disaggregated by age and location (and other characteristics as relevant) currently use female condoms?
- Are female condoms registered in country? What brands? If not registered, what is the registration process—e.g., time, requirements?
- What regulations or policies govern supply, distribution and availability? How may these affect demand?
- What is the price of female condoms in the private and public sector?
- What is the availability of female condoms by region/district?

Audience and Communication Analysis
Below is an example of a set of questions to consider when conducting audience and communication analysis:

Knowledge and Attitudes
- What proportion of providers, women, men and other audiences is aware of female condoms?
- What proportion of providers, women, men and other audiences has accurate knowledge about female condoms?

- What are the perceived benefits of using female condoms by providers, women and their partners?
- What are the perceived barriers to accessing and using female condoms for providers, women and their partners?
- Are there common misconceptions or misinformation about female condoms?

Normative and Structural Considerations

- What are the gender norms in country among couples, both married and unmarried, and how do these affect female condom use?
- Under what circumstances is it acceptable to use female condoms? Under what circumstances is it not acceptable?
- How does the level of income affect use of female condoms? Do poorer women and couples have access to both information and product?
- Who are the stakeholders, key players and gatekeepers who impact or influence demand and utilization of female condoms?
- How are these stakeholders, key players and gatekeepers influencing demand and utilization of female condoms?

Service Provision

- Do providers have adequate skills to counsel on female condoms?
- Are HIV and family planning services integrated with other services?

Media and Communication

- Do couples communicate about using female condoms or similar commodities?
- Through what channels (including media and interpersonal) do providers, women and their partners prefer to receive health-related information?
- What channels can support the level of communication needed to increase knowledge of sexual and reproductive health and demand for female condoms?
- What communication materials and programs already exist related to female condoms?
- What is the technical and organizational capacity of media partners?

Psychographics

- What do providers, women and their partners value? What are their core beliefs?
- Who and what influences providers, women and their partners' decisions and behaviors?
- What dreams do providers, women and their partners have? What do they aspire to in life?
- What are providers, women and their partners' biggest worries? What fears keep them up at night?
- How do providers, women and their partners spend their days? Where do they go? What do they do? What are their hobbies and habits?
- How do providers, women and their partners perceive themselves? How do they want to be perceived by others?

How to use the situation analysis

After conducting a situation analysis, program managers should be able to identify the key implications or challenges from the data. What are the reasons that female condoms are not being utilized? What do potential users—end user, health care providers and health educators—believe about the commodity? Finally, select only a few key factors that the demand generation strategy will address. While it is tempting to address all factors, communications programs will be more successful if they focus on the top few factors that will have the biggest impact given available resources.

It can be helpful to organize the collected information—in order to distill the most important information—using a simple table organized by intended audience, such as the one below.

	Current Behaviors	Primary Barriers to Desired Behavior	Primary Benefits of Desired Behavior
End user/community members (e.g. women, men, caregivers)			
Providers (including public and private, clinic- and community-based)			

In order to maintain an actionable focus throughout the strategy design, it is also helpful to synthesize the implications of this information. Population Services International's Global Social Marketing Department offers the following series of questions to guide the development of a situation analysis and the selection of strategic priorities to be addressed by the demand generation strategy:

What?	So What?	Now What?
Data Collection: Key facts collected during the situation analysis.	**Data Analysis:** Possible implications that the facts may have on the demand generation strategies.	**Strategic Priorities:** Identify which implications to address in the demand generation strategy. Limit to three to five strategic priorities in order to focus the plan.
Example from Zimbabwe:		
Perceived affordability and ease of use may encourage couples to try the female condom, but may not lead to consistent use. PSI data show that reasons for use vary between marital and non-marital relationships. Married women and men are more likely to use female condoms consistently for pregnancy prevention, whereas consistent use with non-marital partners is driven by strong belief in its efficacy for dual protection against STI/HIV and unintended pregnancy.	The female condom may need to be positioned differently to (a) married or cohabiting audiences and (b) women and men who are not in marital or cohabiting relationships. Because approximately two-thirds of intended users are married or cohabiting, positioning the female condom for use in long-term relationships as a family planning method first and foremost, may be the most effective way to create demand in the general population.	• Articulate a unique set of contraceptive and emotional benefits of female condom use that reflects the priorities of women in long-term relationships. • Reach married and cohabiting women with female condoms, key messages articulating the above benefits and critical skills training (e.g., use and negotiation skills). • Create awareness of and openness to female condoms among married and cohabiting men. • Identify below-the-line and/or niche marketing opportunities to promote the dual protection benefits of female condoms to single women and men.

Source: Meekers & Richter, 2005.

Step 2: Define a Vision

The vision anchors a communication strategy by stating what the program hopes to achieve. A vision statement sets forth the direction the strategy should follow and defines clearly and succinctly how the demand generation activities will affect the broader commodity and health environment. The vision should paint a mental picture of a desired scenario in the future.

The vision should be agreed upon by the stakeholders involved in the strategy design process and will thus be "shared" by all. This shared vision is a short statement that articulates what is important, illustrates what is desired in the future for the commodity once the demand generation strategy is successfully implemented and clarifies the goal of the demand generation strategy. The shared vision ensures that all stakeholders are working toward the same goal and guides the strategy design and development process.

In addition, a true vision should be realistic, concrete and attainable given the resources available. The vision should also communicate enthusiasm, be inspirational, and foster commitment and dedication from stakeholders toward the shared goal.

Some organizations call the vision the "Goal" or the "Primary Objective."

An example of a vision statement for female condoms is:

Women who need to protect themselves against both STIs/HIV and unintended pregnancy choose the female condom as part of their method mix because:

- *Women can insert the female condom in their own body and negotiate its use with their male partner.*
- *With adequate practice, female condoms are very easy and pleasurable to use.*
- *Female condoms offer both partners in heterosexual couples an alternative means of dual protection.*
- *The female condom provides dual protection with no side-effects.*
- *The female condom is a coitus-dependent method that is used only when needed.*

Step 3: Choose the Intended Audiences

Segment the Audiences

Segmentation is the process of identifying unique groups of people, within larger populations, which share similar interests and needs relative to the commodity. If the group shares common attributes, then the members are more likely to respond similarly to a given demand generation strategy. Segmenting allows for targeted use of limited resources to those populations that would most affect increased demand. It ensures that the activities developed and implemented are the most effective and appropriate for specific audiences and are focused on customized messages and materials.

Using key findings collected from the situation analysis, the first step in audience segmentation is to answer the question, "Whose behavior must change in order to increase demand and appropriate use of the commodity?" Initial segmentation is often based on demographics, such as age, sex, marital status, education level, socio-economic status, employment and residence (urban/rural). Audiences can be further segmented by psychographics—people's personalities, values, attitudes, interests and lifestyles.

Primary audiences are the key people to reach with messages. These may be the people who are directly affected and who would directly benefit from the use of the commodity. Or they may be the people who can make decisions on behalf of those who would benefit from the commodity. Primary audiences may be further segmented into sub-audiences. For example, identifying specific segments of women of reproductive age who may share common attributes, such as young unmarried women, married women or high-parity women.

Influencing audiences are people who can impact or guide knowledge and behaviors of the primary audience, either directly or indirectly. Influencing audiences can include family members and people in the community, such as community leaders, but can also include people who shape social norms, influence policies or affect how people think about the commodity. Prioritizing key influencing audiences by an estimated power of influence related to increasing demand and uptake of the commodity is crucial. For example, male partners are a likely key influencing audience, but the level of influence (low, moderate, strong) may depend on country context and/or commodity and should be discussed among stakeholders. In order to prioritize influencing audiences, a table like the one below can be helpful.

	Primary Audience Influenced	Estimated Power of Influence (Low, Moderate, Strong)	Attitude Toward Use of Female Condoms or Similar Commodities
Influencing Audience 1			
Influencing Audience 2			

Primary or influencing audiences for demand generation may also include national, sub-national or community-level decision makers, such as legislators and religious leaders, as they can be instrumental in removing or creating access barriers or spreading misguided beliefs about the product.

Involving decision makers and influencers from the political and media realm—and carefully considering the legal and policy environment—is important to ensure demand generation efforts are not hindered by political or social barriers. *Scaling Up Lifesaving Commodities for Women, Children and Newborns: An Advocacy Toolkit* (http://www.path.org/publications/detail.php?i=2381) provides advocacy resources to raise awareness and engage stakeholders in addressing commodity-related gaps in policy. Therefore, advocacy audiences are not included in this communication strategy.

Develop Audience Profiles

Audience profiles are the cornerstone of a communication strategy. They first help bring to life and personify each audience segment, which subsequently guide communication messaging and activity planning. The profile should embody the characteristics of the specific audience, with a focus on telling the story of an imagined individual within the group who can neutrally represent the intended audience. Basing decisions on a representative, personalized example from a specific audience segment, rather than a collection of statistics or a mass of anonymous people, allows for more intimate knowledge of that audience segment and better defined and focused communication strategies. Therefore, the profile is important to ensure the messages are tailored to members of this selected group, resonate with them and motivate them to take action.

Audience profiles for each audience segment are developed using the information collected in the situation analysis. The profile consists of a paragraph that should include details on psychographics, such as current behaviors, motivation, emotions, values, and attitudes, preferred sources of information and access to communication channels, as well as socio-demographic information such as age, income level, religion, sex and place of residence. The profile should exemplify the primary barriers to the desired behavior relative to the audience segment. The profile may include the name of this individual or a photo that represents this person to help visualize who this person is and tell his or her story. It is important to keep in mind that:

1. No two audience profiles look the same as the same data will not always be available for each audience segment.
2. The best profiles use qualitative research as a source.
3. Profiles are to be living documents and regularly updated when new information becomes available.

If the information gathered in the situation analysis lacks detail on a particular audience segment, additional research may need to be conducted to address the identified gaps. For example, for all provider audiences, it may be especially important to conduct formative research around provider attitudes and other drivers to provider behavior that could be used to better inform the audience profile and strategic design.

Step 4: Design Message Strategy (Objectives, Positioning, Key Messages)

The message strategy is one of the most important elements of a communication strategy. It drives the rest of the program and ensures synergy, consistency and coordination for the purposes of shared objectives and clear, harmonized messaging among all stakeholders and partners. A message strategy is designed for each primary and influencing audience and includes: (a) communication objectives, (b) positioning and (c) key messages. As previously mentioned, audience profiles are used to determine whether or not the objectives, positioning and key messages are appropriate for that individual.

(a) Objectives

Communication objectives are measurable statements that clearly and concisely state what the target audience should know (think), what they should believe (feel) and what they should do (behave), as well as the timeframe required for the change. "SMART" objectives are Specific,

Measurable, Attainable, Relevant and Time-bound. Communication objectives should be derived from available evidence on the factors that drive or inhibit adoption by target users, as well as influencing audiences.

(b) Positioning

Positioning is the heart of the demand generation strategy and identifies the most compelling and unique benefit that the product offers the target audience. Positioning is often the emotional "hook" upon which the demand generation strategy hinges. Effective positioning moves beyond the functional benefits of the commodity and appeals to the target audience with emotional benefits.

Positioning presents the desired behavior in a way that is both persuasive and appealing to the intended audience. It provides direction for developing a memorable identity, shapes the development of messages and helps determine the communication channels to be used. Positioning ensures that messages have a consistent voice and that all planned activities reinforce each other for a cumulative effect.

As part of the positioning, a **key promise** is identified that highlights the main benefit associated with the proposed change. Changes in behavior, policies and social norms are made only because there is a perceived benefit to those changes. The benefit must outweigh the personal cost of the change.

An accompanying **support statement,** also called a "reason to believe" in marketing, describes why the audience should believe the promise. This could be based on data, peer testimonials, a statement from a reliable source or a demonstration. The key promise and support statement should include a balance of emotion and reason.

(c) Key Messages

Key messages outline the core information that will be conveyed to audiences in all materials and activities. Messages cut across all channels and must reinforce each other across these channels. When all approaches communicate iterative and harmonized key messages, effectiveness increases. Well-designed messages are specific to the audience of interest, and clearly reflect both a specific behavioral determinant and positioning. They also clearly describe the desired behavior, which must be "doable" for the audience. Key messages are not the text that appears in print materials (taglines) or the words that are used to define a campaign (slogans). Creative professionals are often hired to translate key messages into a creative brief, which is a document for creative agencies or internal teams that guides the development of communication materials or media products, including taglines and slogans.

It is important that key messages are always:

- Developed on the basis of country-specific formative research.
- Derived from context-specific, strategic choices regarding segmentation, targeting and positioning.
- Addressed to known drivers of and barriers to behavior change in the country context.
- Pre-tested with the target audience and refined based on audience engagement.

Step 5: Determine Activities and Interventions

Activities and interventions allow for communication of key messages through a variety of communication approaches and channels. Messaging and media selection (i.e. channels) are best considered and selected together in order to effectively transmit information to the intended audiences. Activities should be carefully selected based upon type of messaging, ability to reach the intended audience through a variety of media/channels, timeline, cost and available resources.

It is helpful to refer to findings from the situation analysis to guide selection of activities and interventions. *A Theory-based Framework for Media Selection* in demand generation programs (http://sbccimplementationkits.org/demandrmnch/media-selection) is a helpful guide to inform media selection decisions based on communications theory. Table 1 is an overview of the types of strategic approaches that can be used. Any demand generation program should include activities across a range of different intervention areas and communication channels, which communicate mutually reinforcing messages.

Table 1: Overview of Strategic Approaches that Can Be Used in Demand Generation
Advocacy: Advocacy operates at the political, social and individual levels, and works to mobilize resources and political and social commitment for social change and/or policy change. Advocacy aims to create an enabling environment at any level, including the community level—e.g., traditional government or local religious endorsement—to ask for greater resources, encourage allocating resources equitably and to remove barriers to policy implementation. *Scaling Up Lifesaving Commodities for Women, Children and Newborns: An Advocacy Toolkit* provides advocacy resources for utilizing the Commission platform to raise awareness and engage stakeholders in addressing commodity-related gaps in policy. See http://www.path.org/publications/detail.php?i=2381.
Community-Based Media: Community-based media reach communities through locally established outlets. Such outlets include local radio stations and community newsletters/newspapers, as well as activities, such as rallies, public meetings, folk dramas and sporting events.
Community Mobilization: Community mobilization is a capacity building process through which community individuals, groups or organizations plan, carry out and evaluate activities on a participatory and sustained basis to improve their lives, either on their own initiative or stimulated by others. A successful community mobilization effort not only works to solve problems, but also aims to increase the capacity of a community to successfully identify and address its own needs. For guidance on community mobilization see *How to Mobilize Communities for Health and Social Change* (Howard-Grabman & Snetro, 2003), available at http://www.jhuccp.org/resource_center/publications/field_guides_tools/how-mobilize-communities-health-and-social-change-20.
Counseling: Counseling is based on one-to-one communication and is often done with a trusted and influential communicator, such as a counselor, teacher or health provider. Counseling tools or job aids are usually also produced to help clients and counselors improve their interactions, with service providers trained to use the tools and aids.
Distance Learning: Distance learning provides a learning platform that does not require attendance at a specific location. Rather, the students access the course content either through a radio or via the Internet and interact with their teacher and fellow classmates through letters, telephone calls, SMS texts, chat rooms or Internet sites. Distance learning courses can focus on training communication specialists, community mobilizers, health educators and service providers. Additional information on eLearning can be found at Global Health eLearning Center and PEPFAR eLearning Initiative.
Information and Communication Technologies (ICTs): ICTs are fast growing and evolving platforms for electronic and digital technologies, including computing and telecommunications technologies, which enable communication and promote the interactive exchange of information. ICTs also include mobile and smart phones, the use of SMS and social media, such as Facebook, Twitter, LinkedIn, blogs, e-Forums and chat rooms. This approach also includes websites, e-mails, listservs, eLearning, eToolkits and message boards. Digital media can disseminate tailored messages to the intended audience on a large scale while also receiving audience feedback and encouraging real-time conversations, combining mass communication and interpersonal interaction. *A Theory-based Framework for Media Selection in Demand Generation Programs* (http://sbccimplementationkits.org/demandrmnch/media-selection) and *Utilizing ICT in Demand Generation for Reproductive, Maternal, Newborn and Child Health: Three Case Studies and Recommendations for Future Programming* (http://sbccimplementationkits.org/demandrmnch/ict-case-studies) are useful resources for program managers looking to utilize ICT in demand generation activities.
Interpersonal Communication (IPC)/Peer Communication: Interpersonal and peer communication are based on one-to-one communication. This could be peer-to-peer communication or communication with a community health worker (CHW), community leader or religious leader.
Mass Media: Mass media can reach large audiences cost-effectively through the formats of radio, television and newspapers. According to a review of mass media campaigns, mass media campaigns that follow the principles of effective campaign design and are well executed can have small to moderate effect size not only on health knowledge, beliefs and attitudes, but also on behavior (Noar, 2006). Given the potential to reach thousands of people, a small to moderate effect size will have a greater impact on public health than would an approach that has a large effect size, but only reaches a small number of people.
Social Mobilization: Social mobilization brings relevant sectors, such as organizations, policy makers, networks and communities, together to raise awareness, empower individuals and groups for action, and work toward creating an enabling environment and effecting positive behavior and/or social change.
Support Media/Mid-Media: Mid-media's reach is less than that of mass media and includes posters, brochures and billboards.

It is also important to consider linkages with other new or existing programs and systems, both those directly related to demand and those less closely connected, but that have an impact on demand or could be utilized to improve efficiency. The following are examples of potential areas for linkages when designing a demand generation program for female condoms:

- Other reproductive health and/or family planning programs that do not currently include female condoms as part of the method mix.
- Quality of care improvement initiatives for service providers/clinics.
- Pre-service education and existing continuing education or in-service refresher training initiatives for clinical and non-clinical providers.
- Supply chain management and market shaping;
- Private sector approaches [For a guide to PPPs in demand generation, see *The Guide to Public-Private Partnerships in Increasing the Demand for RMNCH Commodities* (available at http://sbccimplementationkits.org/demandrmnch/public-private-partnerships); for supply chain management, see the *Private Sector Engagement Toolkit* (available at http://www.everywomaneverychild.org/images/content/life-saving-commodities/Private_sector_engagement_A_%20toolkit_for_Supply_Chains_in_the_Modern_Context.pdf)].
- Non-family planning programs, such as immunization, antenatal/postnatal care etc. (e.g., to provide counseling, disseminate materials) – at both the clinic and community levels.
- Private sector social franchises—especially those targeting WRA or women at an increased risk for HIV and STIs; and
- Cross-sectoral programs (e.g., education, economic empowerment, transport).

Step 6: Plan for Monitoring and Evaluation

Monitoring and evaluation (M&E) is a critical piece of any program activity because it provides data on the program's progress toward achieving set goals and objectives.

Although planning for M&E should be included in the communication strategy, avoid developing a complete monitoring plan at the time of strategy development—e.g., indicators, sample, tools, who will monitor, frequency of data collection. At the time of strategy development, focus on the indicators that should be incorporated into the program's plan. M&E indicators should be developed based on formative research and should indicate whether the key messages and strategies are having the desired effect on the intended audience.

A full M&E plan should then be developed as a separate program document. Developing an M&E plan should outline what indicators to track, how and when data will be collected, and what will happen to the data once they have been analyzed. A variety of data sources can be used to collect M&E data. It is important to assess the scope and context of the program to choose the most applicable methodology, as M&E activities vary in cost, staff and technology requirements. While some lower-cost M&E options will allow for identification of trends in demand for services, they may not be able to provide additional insight into the causal effects of activities and the function of the program. To measure cause and effect, larger program-specific data collection activities geared toward evaluation are needed. See Table 2 on the next page for examples of low- and high-cost options.

While the collection of M&E data tends to receive the most attention, it is also critical to have a process for analysis and review of the collected data. M&E data should be used to inform program changes and new program development. It is best to build these M&E review processes into existing program management activities to allow for regular dissemination of M&E indicators.

Table 2: Examples of Low- and High-Cost Options of M&E for Demand Generation
Low-cost option: A low-cost option makes use of existing data sources and opportunities to gain insight into the program and its associations with changes in demand or uptake. However, it will only allow for the identification of trends and will not allow for the attribution of change to a given program or to program activities.
Illustrative data sources for a low-cost option include: • Service statistics (information from clinics and providers, such as referral cards and attendance sheets). • Communication channel statistics (information from television or radio stations on listenership of mass media activities). • Omnibus surveys (addition of questions related to program exposure and impact to omnibus surveys). • Provider self-reported data (small-scale surveys among providers about services rendered). • Qualitative data (focus group discussions, in-depth interviews). • Demographic and Health surveys (trends in contraceptive prevalence and method mix—about every five years).
High-cost option: A high-cost option makes use of representative program-specific surveys and other data collection methods to gain considerable insight into the effects of the program and the way in which it worked.
Illustrative data sources for a high-cost option include: • Service statistics (information from clinics and providers, such as referral cards and attendance sheets), as well as records tracking product provision and distribution. • Communication channel statistics (information from television or radio stations on listenership of mass media activities). • Provider self-reported data (surveys among providers about services rendered). • Qualitative data (focus group discussions, in-depth interviews, photo narrative, observation visits). • Large, nationally representative program-specific surveys (focus on issues related to knowledge, perceptions, acceptability and use). • Client exit interviews (exit interviews will assess user satisfaction with services delivered, including their perceptions, experience and intentions).

In the areas of family planning and HIV prevention, where demand generation for female condoms can potentially contribute to health impact, governments and their international development partners are ever more focused on strategic allocation of financial, human and other resources. To sustain interest and funding at the global and country levels, female condom programs must show objectively verifiable outcomes—e.g., changes in behavior—from which health impact measures—e.g., numbers of maternal deaths and STI/HIV cases averted—can be derived. Cost-benefit analyses are likely to feature prominently in discussions of female condom targeting strategies. The costs of adding female condoms to male condom or contraceptive delivery systems targeting different audiences should inform female condom marketing decisions. M&E should also measure the cost of each additional sex act protected by female condoms, in order to advance the debate over the female condom's health impact potential and its cost efficiency relative to other investment options.

Indicators

M&E indicators should include process, output, outcome and impact indicators. (See next page.)

Process Indicators	Program Output Indicators	Behavioral Outcome Indicators	Health Impact Indicators
Measure the extent to which demand creation activities were implemented as planned.	Measure changes in audiences' opportunity, ability and motivation to use female condoms, and the extent to which these changes correlate with program exposure.	Measure changes in audiences' condom use behavior and the extent to which these changes correlate with program exposure.	Measure changes in health outcomes.
Example: Number of IPC sessions conducted on family planning methods, including female condoms, with women of reproductive age.	Example: Proportion of women of reproductive age who report that they know where to access female condoms.	Example: Proportion of women of reproductive age who use female condoms.	Example: Reduction in the percentage of unintended pregnancies in women of reproductive age.

Key issues to consider when developing indicators include:

Disaggregation: To increase the utility of M&E data, indicators should be disaggregated to facilitate more in-depth analysis of program performance. It is recommended that indicators in female condom program M&E frameworks are disaggregated by:

- *Condom type.* Behavioral studies should collect data on female condom use alongside data on male condom use. In this way, the effectiveness of female condom programs in increasing overall levels of condom use can be determined.
- *Gender.* Disaggregating M&E data by gender can illustrate the impact of female condom programs on women's empowerment—for example, by showing that the gap between reported condom use by men and women reduced at the same time as female condom uptake has increased.
- *Age.* To facilitate international comparability, programs should, at minimum, be able to report data separately for beneficiaries ages 15–19, 20–24 and 25–49 years old. Based on audience segmentation at country level, programs may wish to disaggregate the 25–49 year age group further, in order to determine the extent to which interventions are reaching those for whom they were designed.
- *Partner type.* To facilitate international comparability, programs should, at minimum, be able to disaggregate condom use data by the following partner types: marital partner, co-habiting partner and other partner(s). Based on context, programs may wish to further disaggregate "other partner,"—e.g., other regular partner, casual partner or commercial partner. It may also be relevant to disaggregate condom use data by the marital status of the respondent—e.g., to demonstrate the extent to which condom use has increased among married and co-habiting women, or among single sexually active women.

Bias: Common biases that programmers should be aware of when designing, implementing and interpreting M&E for female condom interventions include:
- *Self-selection bias*—for example, a woman who knows she is able to insert a female condom on a pelvic model may be more likely to agree to demonstrate the method than a woman who has never tried previously.
- *Social desirability bias*—following exposure to health promotion initiatives, intended populations may feel pressured to give "right answers" to survey questions—e.g., to report using a female condom at last sex even though they did not. As demand generation interventions are successful at shaping positive social norms about female condom use, social desirability bias may become more of a challenge in M&E.

An Illustrative Communication Strategy for Female Condoms

Step 1: Analyze the Situation

Refer to page 14 for supporting guidance on this step, as well as "Step 1" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/ch-step1/) for further resources.

Health and Commodity Context

**The majority of the information in this section is a global-level analysis for purposes of illustration. The country-specific situation analysis should be focused on the local context.*

The situation analysis should give programmers and stakeholders a clear, detailed understanding of (a) the current status of female condom use in the country and (b) the factors most likely to influence demand for female condoms within each audience of intended users or intended influencers. These may include perceived need for the product, product-related knowledge, skills and perceptions, and social and cultural norms that may encourage or discourage trial and adoption.

Health Context

The need to improve women's reproductive health has been at the heart of global health and development discourse over the past quarter century, and the successes and weaknesses of efforts to improve women's reproductive health have impacted progress toward MDGs 3, 4, 5, and 6. As post-2015 frameworks for global health take shape, improving women's reproductive health status remains imperative: STI/HIV prevention and family planning programs at all levels must still overcome deep-seated challenges relating to gender inequality and increasing women's control of reproductive and sexual health will be critical to empowering the world's most vulnerable women and improving their quality of life.

Need for Woman-Initiated Methods of HIV Prevention

Biologically, women are more vulnerable to HIV infection than men, and in most parts of the world women are less able than men to decide how and/or with whom they have sex. Wealth inequality, economic dependence on male partners, educational disadvantage and relationship decision-making norms all increase women's vulnerability, with younger and poorer women worse affected. Globally, approximately half of the 35.3 million people living with HIV are women, but in the generalized epidemics of sub-Saharan Africa, women account for 57 percent of people living with HIV (UNAIDS, 2013).

Traditional gender roles and male-female power dynamics are barriers to negotiating safe sex for most women in the world. Unprotected sex within relationships is driven by conflicting norms relating to fidelity and trust: concurrent sexual partnerships are common, but unprotected sex denotes trust between partners. In the generalized epidemics of Eastern and Southern Africa, between 60 percent and 95 percent of new HIV infections are estimated to occur in the general heterosexual population—among people with multiple sex partners, their regular partners and those in stable mutually faithful, but discordant partnerships (Gouws & Cuchi, 2012). Married and co-habiting women are considered a priority high-risk population by many national HIV programs.

Millions of women in transactional partnerships—that leave them dependent on men for survival—have even less power to insist on protection. In most concentrated HIV epidemics, female sex workers are a key population affected by HIV—despite two decades of targeted programming. In many generalized epidemics, HIV prevalence is also higher among female sex workers than in the general female population. Studies around the world have shown that even female sex workers who consistently use condoms with new paying clients are less likely to do so with regular clients and partners, including their non-commercial partners (Deering et al., 2011; Ulibarri et al., 2012; Yam et al., 2013).

Unmet Need for Contraceptive Access and Choice

While global contraceptive use has increased, there are an estimated 132 million WRA (aged 15–49 years) worldwide who are married or in a union, but have an unmet need for contraception; 56 percent of all such women use modern contraceptive methods, while 7 percent use traditional methods and 37 percent use no method. In sub-Saharan Africa, only 16 percent of women who want to avoid pregnancy use a modern contraceptive method and unmet need for contraception is highest in this region (25 percent), followed by the Caribbean (20 percent) (UN, 2011). Lack of contraceptive access leads to approximately 75 million unintended pregnancies in developing countries every year, over 18 million of which result in unsafe abortions. Eighty-six percent of all unsafe abortions occur in developing countries, where they are responsible for an estimated 13 percent of all maternal deaths (WHO, 2011). Globally, it is recognized that expanding method choice is an effective strategy for increasing contraceptive prevalence. When women and couples have access to a wide range of family planning methods, they are more likely to find a method they like and can use over a period of time, switch methods when their circumstances change and realize their intentions regarding lifetime fertility.

Commodity Context

The female condom was hailed by some as a game-changing innovation in reproductive health, HIV prevention and women's empowerment. With protective microbicides for women possibly still decades away, the female condom remains the only woman-initiated method of STI/HIV prevention in existence; it is also the only woman-initiated contraceptive method that offers dual protection against both pregnancy and STI/HIV infection, an essential consideration in generalized HIV epidemics and for most-at-risk women in concentrated epidemics. However, nearly twenty years after the first female condom became commercially available, female condoms have not been well integrated into family planning or HIV prevention programs. Although it has yet to be seen whether female condom programming has the potential to challenge societal norms and shift sexual power dynamics, the female condom can undoubtedly play a unique role in the global plan toward the elimination of new infections among children by 2015 and keeping their mothers alive by: (1) preventing new HIV infections among WRA and (2) helping women living with HIV avoid unintended pregnancies. Approaches that optimize the female condom's contribution to global and national health objectives must be fully explored, and more empirically driven promotion and evaluation carried out to maximize impact and cost efficiency.

Products Available

Although there are now multiple female condom products under development, only two are WHO approved—the FC2® and Cupid®. The main female condom that has been distributed to date is the Female Health Company's FC1® and FC2®. Several new products are now in early stage introduction.

Most female condoms share fundamental design features. A female condom is a soft sheath with an insertion device at one end (e.g., a ring, sponge or dissolving capsule) and a ring or frame at the other to secure the condom during sex. It is inserted in the vagina before sex and provides a physical barrier to sperm and infections. An advantage of all female condoms is that men do not need an erection to use it; therefore, the female condom can be inserted by the woman during foreplay and the man does not need to withdraw immediately after ejaculation.

The first commercially available female condom (or 'femidom') FC1®, was made of polyurethane and launched by the Female Health Company in 1992 and approved by the U.S. Food and Drug Administration (USFDA) in 1993. Ninety million female condoms were distributed worldwide between 1996 and 2005. From 2002–2005 global distribution plateaued at 12–14 million units annually, but between 2005 and 2009, female condom distribution more than tripled. In 2009, combined sales of the FC1® and FC2® reached 50 million units (Frost & Reich, 2009; UNFPA, 2011b).

The high production cost of the FC1® was a barrier to large-scale donor support. At the same time, significant cultural taboos in many target countries—coupled with the product's unfamiliar attributes—hindered trial and adoption of the FC1® and, critically, its promotion by health providers. In 2006, the Female Health Company launched the lower-cost FC2® to address these barriers. In the last five years, a number of other female condom products have entered the market, enhancing product choice for programmers, but also necessitating more nuanced advocacy and demand generation approaches (Beksinska 2012b).

The two female condom products currently prequalified by WHO and available for bulk procurement are the FC2® and the Cupid® female condom. Other condoms, such as the Woman's Condom, the Phoenurse™, the HLL Female Condom, the Origami™ female condom and the VA worn-of-women (VA w.o.w.®) condom, are still under development or undergoing clinical trial.

These products are described briefly below [Information correct as of September 2013. Source: Universal Access to Female Condoms (UAFC) Joint Programme. Female condom: Product brief. (2013).]

Product		Design & Features	Manufacture & Distribution	Regulatory Status
FC2®		• Identical to FC1®, but made of nitrile (synthetic latex). • Flexible circular inner ring to insert the device and keep it in place during use, and a flexible circular outer ring to protect the genital area. • Nitrile material conducts heat.	Manufactured by the Female Health Company, Malaysia. Distributed in 130 countries worldwide.	Contraceptive eligibility (CE) marking WHO pre-qualified 2007, renewed 2012 USFDA 2009
Cupid®		• Made of natural rubber latex. • Has an octagonal outer frame and is inserted using a medical-grade sponge, which also holds the condom in place during use. • Pre-lubricated with silicone oil. • Comes in transparent or pink color, and is the only scented female condom.	Manufactured by Cupid Ltd, India. Distributed in India, Brazil, Indonesia, Netherlands, South Africa, Mozambique and Kyrgyz Republic.	CE marking WHO pre-qualified 2012 USFDA approval process initiated 2012
Woman's Condom		• Made of polyurethane. • Has a soft, rounded insertion capsule, which dissolves quickly after insertion in the vagina. • Four foam shapes on the outside of the condom ensure internal stability. • A flexible circular ring covers and protects the genital area. • Not pre-lubricated: separate water-based lubricant is supplied in a sachet to be applied at point of use.	Manufactured by Shanghai Dahua Medical Apparatus Company, China. Limited distribution in China and South Africa.	CE marking Under review for WHO pre-qualification Currently undergoing contraceptive effectiveness study needed for USFDA approval
Phoenurse®		• Made of polyurethane, which conducts heat. • The body is dumbbell-shaped, with a flexible circular inner and outer ring. • Marketed with an insertion stick, which attaches to the inner ring for optional use during insertion into the vagina. • Pre-lubricated with a silicone lubricant.	Manufactured by Tianjin Condombao Medical Polyurethane Tech. Co. Ltd, Tianjin, China.	CE marking

Product		Design & Features	Manufacture & Distribution	Regulatory Status
HLL Female Condom		• Made of natural rubber latex. • Has an outer flexible circular ring and is inserted with an inner flexible circular copolymer ring, to aid retention during sexual intercourse.	Manufactured by Hindustan Lifecare, Ltd (HLL), India.	Currently undergoing functionality study. The results of the study will be part of the product dossier to be submitted for WHO pre-qualification.
Origami™ Female Condom		• Made of transparent, molded silicone. • Anatomical, ridged design. • Fluid lining mimics the vaginal environment for the penis, creating a more natural sensation.	ORIGAMI Condoms Ltd, California, USA.	Large-scale clinical trials set for 2014, with the product expected to reach the market in late 2015, subject to approvals.
VA w.o.w.® (worn of women)		• Made of natural rubber latex. • Has a rounded triangular frame for outer retention and a polyurethane sponge to secure it inside the vagina. • Pre-lubricated with a silicone lubricant.	Manufactured by Hindustan Lifecare, Ltd (HLL), India.	HLL acquired the technology and marketing rights for production and marketing of VA w.o.w.® brand of female condoms in 2013.

Product Efficacy

Used correctly, female condoms are approximately 95 percent effective in preventing semen exposure that could lead to STI/HIV infection or unintended pregnancy; this is comparable to the efficacy of male condoms (UNFPA & WHO, 2006). In a six-month clinical trial in the United States, 12 percent of women became pregnant with typical use of the female condom, while under 3 percent became pregnant with perfect female condom use (Trussel, 2011). A WHO-mandated, multi-center study comparing female and male condoms determined effectiveness rates in Panama, China and Nigeria, of 94–98 percent for the FC1® and 92–96 percent for the male condom (UNFPA & WHO, 2006).

A study in South Africa found comparable rates of total clinical failure for the FC1® (5.4 percent) and FC2® (4.3 percent) (Beksinska, Smit, Mabude, Vijayakumar, & Joanis, 2006). Aspects of clinical failure are defined in the table below. This finding is consistent with 95.5 percent efficacy in a U.S. study in Alabama that compared male and female condom (FC1®) efficacy (Valappil et al., 2005). Although mechanical problems were reported more frequently by female condom users than by male condom users in this study (34 percent and 9 percent respectively), total failure rates among those users reporting mechanical problems were the same for female and male condoms (9.4 percent and 9.6 percent respectively). The Alabama study underscored the importance of practicing with the female condom until one becomes comfortable using it. Comparing first use to fifteen or more uses, the rate of self-reported failure (breakage or slippage) for female condoms fell from 20 percent to 1.2 percent (Valappil et al., 2005).

Female condoms are less likely to break than male condoms—only 0.85 percent of FC2®s tested in the South Africa trial broke. The same trial also found that the FC2® halved incorrect penetration (i.e. the penis entering between the condom and the vaginal wall)—from 1.26 percent using the FC1® to 0.6 percent using the FC2®, whereas the outer ring of both FC1® and FC2® displaced in 3 percent of uses (Beksinska et al., 2006).

In 2011-2012, UAFC supported a comparative functionality study of four female condoms at sites in China and South Africa: FC2®, Cupid®, the Woman's Condom (WC) and the VA w.o.w.®. Total failure ranged from 3 percent to 4.5 percent (see table below) (Beksinska et al., 2013).

Functionality (percent)	FC2	Cupid	WC	VA w.o.w.
Clinical breakage (during intercourse or withdrawal of condom from vagina)	0.25	0.10	0.00	0.08
Non-clinical breakage (before intercourse or after withdrawal of condom)	0.62	0.66	0.74	0.53
Invagination (condom pushed into vagina)	1.18	1.21	0.47	0.99
Slippage of condom out of vagina	0.98	1.48	1.28	0.43
Misdirection (penis did not enter condom)	0.60	1.22	1.13	1.19

Programmatically, a vitally important dimension of female condom efficacy is the extent to which adding female condoms to the method mix increases the total number of protected sex acts. Evaluations of female condom promotion to family planning clinic clients in California (Choi et al., 2008) and sex workers in China (Liao et al., 2011a) both highlighted the importance of targeted, skills-based female condom promotion in increasing the overall percentage of sex acts protected by either female or male condoms as a result of female condom interventions. A study in Madagascar showed peer education to be as effective as clinic-based promotion of female condoms in increasing overall condom usage when female condoms were introduced to an existing male condom promotion intervention targeting female sex workers (Hoke et al., 2007).

There is some anecdotal evidence from both developed and developing countries that female condoms are used by men who have sex with men for STI/HIV prevention during anal intercourse. However, no published, peer-reviewed evidence yet exists on their safety and efficacy for this purpose. Female condoms are not WHO prequalified for use in anal intercourse and therefore, there is currently no international recommendation that either men or women should use female condoms for STI/HIV prevention during anal sex. Female condoms should never be promoted for anal intercourse because they were not designed to be inserted in the rectum. Removing the insertion device (i.e. the sponge, ring or capsule) distorts the female condom and affects its efficacy. **For this reason, men who have sex with men are not included as an intended audience in this demand generation strategy.**

Audience and Communication Analysis

Over the last twenty years, government and NGO distribution and demand creation initiatives for female condoms have generated evidence on the social and behavioral factors affecting acceptability and use of female condoms. In most studies, female condom use has been low and has generally declined after introductory campaigns, due to lack of sustained availability (Thomsen et al., 2006; Liao et al., 2011b).

A study in Brazil (Kalckmann, Farias, & Carvalheiro, 2009) found that women with more frequent sexual relations (more than three sexual contacts per month) were significantly more likely to become long-term female condom users, whereas women who had one to three sexual contacts per month were more likely to drop out of female condom programs within the first month. This suggests that targeting demand generation efforts to women with higher coital frequency may be an effective approach to increasing uptake.

Relationship norms that govern trust, communication and decision making are a key barrier to use of both male condoms and female condoms. Asking a regular partner to use a condom, or (re-)introducing condoms into a regular partnership, is seen as a sign of cheating or an accusation that one's partner is being unfaithful. Even where women understand the risks associated with their own and their partners' sexual behaviors, they are often powerless to protect themselves due to prevailing gender roles, sexual norms and inequalities in wealth and decision-making power (UNFPA & PATH, 2006). In some cultures, taboos about touching or placing anything in the vagina are a barrier to female condom acceptability and use (Frost & Reich, 2009).

A female condom acceptability study among young South African men identified convenience of use for men, curiosity (to see how female condoms compared to male condoms), enhanced sexual sensation, and perceptions of better safety and comfort as facilitators of female condom use by men. Key barriers were unfamiliarity with female condoms, partner's insertion difficulties and concern about losing control over sexual encounters (Masvawure et al., 2013).

When promoting the female condom as a women's empowerment tool, it is important to remember that there is no universal interpretation of empowerment. Some intended users and program stakeholders may understand empowerment in terms of practical gender-specific interests (e.g., giving women a tool for preventing unintended pregnancy and STI/HIV acquisition), whereas others may think in terms of 'strategic' transformation in gender relations. Because making the female condom acceptable to men is an essential strategy for increasing uptake, programmers should take care not to create negative perceptions of a product that is designed to empower women by taking power away from men (Kaler, 2001).

At the individual level, availability of female condoms, product attributes, perceived effect on male sexual pleasure (and, to a lesser extent, female pleasure), male partner and health provider attitudes, and self-efficacy to negotiate female condom use and insert the product are the factors most likely to determine whether women use female condoms:

- **Product attributes:** The female condom's image is a persistent barrier to uptake. In the absence of positive promotion of product benefits, non-users are likely to consider the female condom large, bulky, aesthetically unappealing and awkward/difficult to use (Okunlola, Morhason-Bello, Owonikoko, & Adekunle, 2006; Telles Dias, Souto, & Page-Schafer, 2006).

- **Pleasure:** The belief that male partners do not or would not like to use the female condom, because a condom reduces male sexual pleasure, is often a barrier to use for women. Conversely, women are more likely to accept and use the female condom if they believe that it can enhance pleasure for men—e.g., compared to male condoms because they do not feel constrained by the female condom during sex. In the South African male acceptability study (Masvuware et al., 2013), the main source of dissatisfaction with female condoms was insertion difficulties during trial. However, some men reported increased sexual pleasure due to the convenience of not having to wear a male condom, increased sensation due to the texture of the polyurethane FC1® and the more comfortable fit of the female condom compared to male condoms. In a study among female condom users in Brazil (Munyana, 2006), some women reported that the female condom's outer ring that stimulates the clitoris enhanced their sexual pleasure.

- **Social support for use of female condoms:** Women's uptake of female condoms is influenced by the attitudes of their male partners and the health care workers and/or health educators from whom they can obtain the female condoms and learn about the method. Despite evolving gender norms in target countries, men are usually the main decision makers in matters relating to sex and proposing a product that her male partner has never seen or used before can be daunting (or even risky) for a woman in any type of sexual partnership. Service providers can play a key role in influencing intended users to try and maintain use of female condoms—equipping providers with product-related training and knowledge has the potential to influence users' attitudes and uptake (Mantell et al., 2011b). Health educators in public sector and NGO programs—e.g., social mobilization and community mobilization interventions—may also play this role. Sufficient, balanced information about the benefits and use of female condoms drives uptake (see "difficulty or ease of insertion" below). It is important that efforts to create demand among women are complemented by awareness raising and distribution targeted to men, as well as by tailored sensitization and skills training for health care workers and health educators. The association of (male) condoms with disease prevention and promiscuity by intended users creates attitudinal barriers to use in marital/co-habiting and other primary or long-term partnerships. The female condom's status as a newer, lesser-known product can represent an opportunity in such settings: for example, a three-country study in Zimbabwe, Nigeria and Cameroon (Koster & Groot Bruinderink, 2012) found high acceptability of female condoms among men for use in marital relationships for family planning only and in other stable relationships for dual protection.

- **Difficulty or ease of insertion:** Total female condom failure rates have been shown to decrease markedly after the first few uses. Regular or experienced female condom users report higher self-efficacy to use the product and lower rates of failure, underlining the importance of sensitization, demonstration, trial and practice in efforts to create new female condom users. A 2008 study in South Africa (Beksinska, Smit, & Mantell, 2012c) showed how practice with female condoms effectively reduces failure rates: for example, slippage rates declined from 2.4 percent with condoms 1–5 to 0.9 percent with condoms 6–10 and no slippage was reported at last use (condom 15).

- **Negotiation skills:** Although the female condom is a woman-initiated method, to negotiate female condom use, women need similar skills to those required to negotiate use of male condoms. Women with higher self-reported negotiation skills are typically more likely to have tried or regularly used female condoms and it seems likely that there is a causal effect between negotiation skills and use. Critically for programmers, studies show that women who receive coaching and counseling in how to talk about female condoms and negotiate their use are more likely to use female condoms than women who receive only information and written instructions (Choi et al., 2008; Liao et al., 2011b; Mack, Grey, Amsterdam, Williamson, & Matta, 2010; Population Council, 2009; Telles Dias et al., 2006). These findings emphasize the importance of incorporating training in sexual negotiation skills into demand generation efforts for the female condom.

The key information garnered from each audience analysis maybe distilled as follows to promote focused and shared understanding (see page 18 for an example).

	Current Behaviors	Primary Barriers to Desired Behavior	Primary Benefits of Desired Behavior
Women in relationships and their primary partners	In most studies, female condom use has been low and has generally declined after introductory campaigns due to lack of sustained availability.	Product attributes Decreased pleasure Poor social support Difficulty to insert Negotiation Association with disease prevention and promiscuity	Dual protection Increased pleasure Female-initiated Perceived safety and comfort
Providers	Low levels of promotion and familiarity with female condoms.	Lack of training Provider biases Limited availability of product	Dual protection from unintended pregnancy and HIV

Step 2: Define a Vision

Refer to page 17 for supporting guidance on this step, as well as "Step 2" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/ch-step2/) for further resources.

Illustrative Vision

Women who need to protect themselves against both STIs/HIV and unintended pregnancy choose the female condom as part of their method mix because:

- Women can insert the female condom in their own body and negotiate its use with their male partner;
- With adequate practice, female condoms are very easy and pleasurable to use.
- Female condoms offer both partners in heterosexual couples an alternative means of dual protection.
- The female condom provides dual protection with no side-effects.
- The female condom is a coitus-dependent method that is used only when needed.

Stakeholders at all levels in HIV, reproductive health and women's empowerment programs value female condoms as a unique asset, and female condoms are actively promoted to women and couples who need them. Female condom initiatives can show evidence of impact, both on the proportion of sex acts protected by a barrier method and on overall contraceptive use.

Step 3: Choose the Intended Audiences

Refer to page 18 for supporting guidance on this step, as well as "Step 3" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/ch-step3/) for further resources.

Primary and Influencing 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 those 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 percent of people living with HIV and 88 percent 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 & Cuchi, 2012). HIV-negative women in serodiscordant 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 wants to avoid unintended pregnancy and protect her long-term partner.
- *Primary Audience 2: Sexually Active Single[2] Women*
  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 at least double that of males of the same age (UNAIDS, 2013). WHO reported on World AIDS Day 2013 that more than 2 million adolescents ages 10 to 19 years old 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).
- *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 serodiscordant couples have a

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

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, 2011b).

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 percent, increasing to over 30 percent 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 percent. In West Africa, UNAIDS estimates that 10 to 32 percent of new HIV infections occur as a result of sex work. Eleven percent of female sex workers in Eastern Europe and 6 percent of female sex workers in Latin America are estimated to be living with HIV (Kerrigan et al., 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 and/or 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 play a critical role in bringing the method into intended users' everyday awareness. Objective, unbiased reporting of the efficacy, attributes and availability of female condoms can increase intended users' receptiveness to promotion efforts. On the other hand, negative or misinformed reporting will hamper demand generation efforts, and an absence of coverage will make 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 theory is used as a framework for the audience profiles (see "Conceptual Framework", page 12). 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 targeting with female condom promotion. As an intended 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: WRA in Long-Term Partnerships, in Generalized HIV Epidemics		
Desired Behavior: Consistent Use of Either Male or Female Condoms with a Regular Partner		
'Before' Archetype A: PAMELA, 26, office clerk, wife and 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.		**'Before' Archetype B: MARGARET, 29, vendor, wife and mother, Zimbabwe – has never used a female condom.** Margaret was diagnosed with HIV three years ago while 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 A: PAMELA, consistent female condom user - key touch-points in her journey		**'After' Archetype B: MARGARET, regular 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.		**Pre-contemplation:** She has heard of female condoms but has never actually seen 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.		**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 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.	 	**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: A few weeks later, she talks to Jackson about coming off the pill and using female condoms as their contraceptive, and 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.		**Action:** Encouraged by their first experience, Margaret initiates female condom use several more times during the following 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: 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.		**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 & Richter, 2005.

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 also has 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, consistent 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 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: 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 and 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 the 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 of 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 that 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 on 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: Masvawure 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, no other job on which to raise her three children and has 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 his 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 pictoral 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 and finds it comfortable to wear; she is able to 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 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: 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, much cheaper, always 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 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 also is 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 HIV-positive women and HIV-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 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 female condom 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.

Source: Mantell, Stein, & Susser, 2008; 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 percent 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 (MOH) is renewing efforts to promote the female condom. Mainly, he is skeptical about the extent to which this is the MOH's initiative or whether the donors are pulling strings again. As a man, 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 divert resources from important HIV prevention interventions like treatment adherence programs, male condom distribution and voluntary 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 and/or 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 female condoms, job aids, posters, anatomical diagrams, instructional brochures and DVDs, and enough pelvic models for every clinic in the district. More 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 creates an action plan for integrating female condom promotion into HIV, STI and family planning counseling at minimal cost.

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 health care 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 percent. 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.

Source: Mantell et al., 2008; Frost & Reich, 2009.

Influencing Audience 1: 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 and/or 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 touch-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 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 out the product. Two days later, an MOH 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 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 but with misgivings. **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, 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. **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. *Source: Mantell, Stein, & Susser, 2008; Frost & Reich, 2009.*

Step 4: Design Message Strategy

Refer to page 19 for supporting guidance on this step, as well as "Step 4" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/ch-step4/) for further resources.

Objectives

Demand generation objectives should articulate clearly what activities will be implemented and what they will achieve, including the changes in audiences' knowledge, beliefs and behaviors they will bring about, as well as the timeframe within which results will be achieved. The framework of measurable communications objectives and related performance indicators linked to female condom demand creation programs should include the following hierarchy of objectives. **Illustrative objectives and corresponding performance indicators are presented under Step 6 below**.

Process Objectives	Program Output Objectives	Behavioral Outcome Objectives	Health Impact Objectives
E.g., Targets for new outlets, numbers of health workers trained in promotion and numbers of education, media or advocacy activities executed.	E.g., Distribution targets, and increase in audiences' opportunity, ability and motivation to use female condoms.	E.g., Distribution targets, and increase in audiences' opportunity, ability and motivation to use female condoms.	E.g., Reduction in HIV incidence, STI incidence and maternal mortality.

Positioning

Overarching Considerations

Positioning should emphasize the female condom's uniqueness and convey the important emotional and functional benefits of female condom use that research has shown to drive trial and adoption. Key factors to consider include:

- De-emphasizing disease prevention in the female condom's positioning aims to remove a critical barrier to condom use within relationships—the association of condoms with mistrust and cheating—and thereby offers a key emotional benefit, more harmonious discussion and agreement on dual protection. This is likely to be the most complex and nuanced aspect of positioning but, if it can be achieved, it has the potential to greatly enhance acceptability.
- Another emotional benefit for women is knowing that they have the means to protect themselves, even in situations where male condoms cannot be used for any reason.
- The female condom's functional benefits relate to its effectiveness in preventing STI/HIV and unintended pregnancy, its usability for women, the fact that it is a woman-initiated product, and the ways in which it creates a pleasurable sexual experience for both partners and offers a different experience to using male condoms.
- For all intended users, an emotional benefit of use that derives from a functional benefit (efficacy) is the peace of mind they gain from knowing they are protected against STI/HIV and unintended pregnancy.

General Population Audiences

In most settings, positioning of the female condom for general population audiences—i.e., women and their primary partners—will need to retain relevance and appeal as audiences move from contemplation through trial, adoption and regular use. Whereas contemplation is driven by women's desire for greater control over STI/HIV prevention, negative perceptions of the female condom's attributes and functionality must be overcome in order to motivate trial. Long-term adoption requires both partners to accept the female condom as a method of contraception and/or health protection. The fact that the female condom is woman-initiated is one of its key points of differentiation. In positioning for couples, care should be taken not to present female condoms in a way that is disempowering to men, but rather as empowering to both partners.

For **single, sexually active women,** the fact that the female condom is a female-initiated method of STI/HIV prevention is more central to its appeal for health protection. It should be possible for niche marketing of female

condoms to emphasize the female condom's uniqueness as a proactive dual protection tool for women without compromising the female condom's overall positioning. This approach has been used in female condom interventions targeting university students as early adopters in countries including South Africa, Mozambique and Lesotho.

Thus, an illustrative, inclusive **general population positioning statement for female condoms in high HIV prevalence settings might be:**
"The female condom is the only woman-initiated method that, once users are familiar with it, is easy, convenient and pleasurable for both partners to use, and places the security of dual protection in women's own hands."

or

"The female condom is the pleasurable and empowering option for safe sex."

Female Sex Workers

For **female sex workers,** the female condom is most commonly positioned as a female-controlled and female-initiated method of STI/HIV prevention that offers an essential alternative to male condoms and increases women's ability to protect their health. In generalized HIV epidemic settings, where female condoms are positioned principally for appeal to married and other long-term couples, their niche positioning for use in commercial sex must be approached with care, using highly targeted approaches. If general population audiences come to associate female condoms with sex work and/or disease prevention, the product could be stigmatized, impacting its overall acceptability. In concentrated epidemic settings, where the key audience for female condoms is female sex workers, an inclusive positioning that emphasizes user control and efficacy for HIV prevention would be appropriate.

An illustrative positioning for female sex workers might be:
"For ladies who care about their health, the female condom is the only product that, once you are used to it, is easy, convenient and pleasurable for you and your partner to use, and places the power of protection against STI/HIV infection and unintended pregnancy in your own hands."

Key Promise

The female condom's key promise—derived from its positioning—should highlight the main benefits associated with use, for example:

- It is a **woman-initiated and woman-inserted method**.
- It is **effective** for use as a contraception method and to prevent STIs and HIV.
- Its **usability** for women is high – it is strong, dependable, convenient and easy to use with a little practice;.
- Product features create a **pleasurable experience for both partners**.
- For influencing audiences, the key promise should also address its programmatic viability in the local context and **potential health impact**.

The relative emphasis of each element of the female condom's overall promise will depend on the intended audience of each program component, the predominant stage of behavior change within that audience, and context-specific evidence regarding drivers of and barriers to change.

Implicit in the female condom's promise to women is that it removes two of men's biggest objections to using male condoms—interrupting their flow during sex and reducing their sensitivity—thus, making it more likely that men will agree to use a form of protection. These promises may be more overt in niche marketing of female condoms to single, sexually active women. More generally, however, promises should focus on the emotional benefits of female condom use and its important functional points of differentiation from male condoms and other contraceptive methods. Promises of efficacy for STI/HIV prevention should be implicit or "taken for granted" in general population demand generation interventions.

- To male partners, the female condom promises a pleasurable sexual experience because it can be inserted during foreplay, is not constricting during sex and does not require immediate withdrawal after ejaculation. The female condom also offers women and men the opportunity to share responsibility for protection and increases couples' options for protection.

- In concentrated HIV epidemics, where female sex workers are the priority intended audience of female condom programs, acceptability to men who do not like to use male condoms is likely to be explicit in the key promise and comparable protection against STI/HIV infection to that offered by the male condom may also be emphasized more strongly.

For the female condom to be a dependable method of protection for all intended users and their partners, the key promise must include dependable access.

Health providers and national stakeholders in high HIV prevalence settings are overwhelmed with urgent health needs and to make the female condom a priority, they must really believe it can make a difference. The female condom's key promise to health providers hinges on its credibility as a viable dual protection alternative to male condoms. Providers must be presented with evidence that female condoms are not just efficacious, but usable and acceptable for women and men in their local context. Stakeholders must believe that renewed efforts to promote the female condom will not drain scarce HIV prevention and women's health resources, but bolster other strategies.

For the female condom to regain and retain credibility with providers and national stakeholders, the key promise must include long-term political commitment and be backed by a dependable female condom supply, as well as effective training, tools and workplace support.

If multiple female condom products are distributed, key promises must either be delivered by all the female condoms distributed in that country, or clearly associated with a particular brand of female condom, to avoid confusing, misleading or alienating audiences.

Support Statement

Each key promise should be accompanied by a support statement that explains why the intended audience should believe it. The key promises above are substantiated by the following support statements:

- **Potential health impact:** Program evaluations show that, when female condom interventions have (a) included insertion and negotiation skills training and (b) targeted men as partners and health providers as influencers in addition to female users, overall condom use has increased.
- **Woman-initiated dual protection method:** The female condom is the only woman-initiated product on the market that prevents both STI/HIV and unintended pregnancy. A woman does not have to depend on her partner to wear a male condom.
- **Effectiveness:** Trial data shows that the female condom is 95 percent effective for prevention of STI/HIV infection and pregnancy. Trials have also shown that female condoms are less likely to break than male condoms.
- **Usability:** (1) The female condom can be inserted during foreplay and left in for hours after intercourse. (2) Behavioral trials show that after practicing two to three times, women find the female condom easy to insert and comfortable to wear. (3) The female condom makes it possible for couples to share responsibility for protection.
- **Pleasurable experience for both partners:** (1) Because the female condom molds to the woman's body, the man does not feel constricted by it during sex. (2) The spontaneity of sex is not interrupted, because the woman can insert a female condom during foreplay. (3) Many women enjoy the clitoral stimulation that the female condom's outer ring gives during sex. (4) Because the female condom does not require an erection to stay in place, the man does not need to withdraw immediately after ejaculation.

Key Messages

Key messages should enable the intended audience to self-select, emphasize key emotional and functional benefits of female condoms, and include a call to action. Messages should be based on formative research and tailored to:

- The predominant stage of change within the audience.
- Identified barriers and facilitators to creating new users in the country context.

Messages to Encourage Contemplation

Messages designed to move intended users and influencing audiences from pre-contemplation to the contemplation stage of behavior change should encourage them to think, or think again, about female condoms and showcase the potential benefits of doing so. Illustrative message components at this stage of behavior change could include:

For general population women, their male partners and female sex workers:

- The female condom was invented to help women to protect themselves when they have sex.
- Women now have an alternative means of dual protection against STI/HIV infection and unintended pregnancy, the female condom.
- Ask for female condoms and more information at your nearest health center or pharmacy.

For influencing audiences:

- Female condoms are back on the agenda. The government is making a commitment to female condoms because they are the only available product that women can use to protect themselves against both unintended pregnancy and STI/HIV.
- The female condom is not a substitute for the male condom, but a complementary alternative that increases overall condom use.
- Find out more about the female condom program—e.g., from this document or at this meeting.

Messages to Encourage Preparatopn and/or Trial

Messages to move intended users and influencing audiences from contemplation of female condoms to trial of the product should present them with important, immediate benefits of trying female condoms, as well as managing new users' expectations so they do not become discouraged by any difficulties they encounter with the first few condoms.

Illustrative message components at this stage of change could include:

For all intended users:

- Many men like female condoms because they do not feel constrained by the female condom during sex.
- After practicing a few times using instructions, most users find the female condom easy to insert and remove and comfortable to wear.
- Try female condoms for yourself. They are available at your local health center or pharmacy.

For women:

- Empower yourself with the female condom.

For all influencing audiences:

- The female condom can prevent HIV transmission in this community by offering couples a dual protection alternative to male condoms.
- For women, the female condom is easy to use, but it takes practice. After practice on the demonstration model and two or three practice insertions following the instructions, women will be comfortable inserting and using the female condom.
- Many men say that sex is more pleasurable with a female condom—because it molds inside the woman's body, men can hardly feel it during sex.
- Play your part in making this essential commodity available in this community.

For health providers and health educators:

- Including the female condom in counseling sessions will only take a few minutes and that is a worthwhile investment of your time.

For stakeholders:

- You will have the commodities, support materials and training you need to integrate female condom promotion into existing programs with minimal opportunity cost.

Messages to Encourage Action

Messages to achieve the critical step of translating female condom trial into ongoing use must encourage intended users and influencing audiences to truly embrace and identify with the product, by presenting them with important benefits of doing so that resonate with the experience of trial and outweigh the perceived costs of female condom use or promotion.

Illustrative message components at this stage of change could include:

For intended female users:
- Once you are used to the female condom, it is convenient, easy and comfortable to use.
- The female condom makes sex pleasurable for both partners.
- With the female condom, you are in control.
- With the female condom, you can take responsibility for protection when your partner does not use a male condom.

For women in generalized HIV epidemics and their male partners:
- Use female condoms to avoid unintended pregnancy and keep yourself healthy.

For female sex workers:
- The female condom is comfortable to wear and gives you effective protection.
- Use female condoms to stay in control and protect your health.
- It can be easier to negotiate female condom use with a client or non-commercial partner than it is to negotiate use of male condoms.

For influencing audiences:
- Many couples who try the female condom like it and will use any condom more often as a result. The more couples we can introduce to female condoms, the more STI/HIV infections and unintended pregnancies can be prevented.
- The government is serious about female condoms as a long-term strategy. Do not be scared to create demand; the female condom users you create will always have a reliable supply.
- Help to build on the success of the female condom program so far.

Messages to Encourage Maintenance

Messages to translate medium-term programmatic gains into sustained use and support should remind users and female condom champions of the long-term benefits of female condoms. These might be benefits that capture the most positive aspects of regular use from the user's perspective, or that remind them of benefits so inherent in the experience that they are now taken for granted.

Illustrative message components at this stage of change might include:

For all intended users:
- The female condom offers convenient, pleasurable dual protection for both partners.
- The female condom is strong and reliable, yet men barely notice it during sex.
- Make female condoms part of your relationship.
- Do not be caught without the female condom. You can always find them at the [e.g., clinic, pharmacy, other outlet].

For female sex workers:
- Always keep a supply of female condoms to hand, to ensure that you can protect yourself if a client refuses to use male condoms.

For influencing audiences:
- Female condoms are here to stay and they are helping to save lives thanks to your efforts to promote them.

Step 5: Determine Activities and Interventions

Refer to page 20 for supporting guidance on this step as well as "Step 5" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/ch-step5/) for further resources.

Suggested approaches and activities are presented here as appropriate choices for communicating to primary and influencing audiences about female condoms. These suggestions are a starting point, and close collaboration with communication and creative professionals can help ensure that design and execution are innovative and compelling.

Illustrative activities for a demand generation program on female condoms are tabulated below based on five key intervention strategies:

1. **Integrating female condom promotion into existing services and programs such as:**
   - Clinic-based services, such as family planning, RMNCH, prevention of mother-to-child transmission of HIV, HIV counseling and testing, voluntary medical male circumcision and STI treatment.
   - Community-based health services and health education programs.
   - Community mobilization initiatives, particularly those focusing on women's empowerment and gender/relationship norms, youth/adolescent friendly services, and support services for individuals and families affected by HIV.
   - Life skills programs, particularly those teaching communication and negotiation skills to women and girls.
   - Outreach programs targeting female sex workers and their clients, and including sex work organizations and networks.
   - Formal and informal workplace programs targeting key industries—e.g., food, agriculture and mining industries, brothels and uniformed services.
   - Social marketing programs and public sector condom distribution networks.

2. **Creating awareness and acceptance of female condoms among all audiences through:**
   - IPC.
   - Community mobilization, including EE.
   - Mass media promotion, including EE.
   - Media engagement and mass media reporting.
   - Social media and websites.

3. **Leveraging the private sector through:**
   - Traditional private sector condom outlets, e.g., pharmacies, clinics.
   - 'Non-traditional' private sector condom outlets, e.g., bars.
   - Outlets frequented by intended female condom users, e.g., hair salons.
   - Training for staff of private sector outlets.

For a guide to PPPs in demand generation, see *The Guide to Public-Private Partnerships in Increasing the Demand for RMNCH Commodities* (available at http://sbccimplementationkits.org/demandrmnch/public-private-partnerships).

4. **Creating momentum and capacity by training nurses, lay counselors, pharmacists and community health workers through:**
   - Pre-service training

- In-service training
- Medical detailing

5. **Building stakeholder support through targeted advocacy and participation, including:**
    - Sensitization meetings, presentations, workshops and conferences.
    - Participation in technical working groups—e.g., on HIV, family planning, RMNCH, gender and women's empowerment.
    - Participation in health sector policy, strategy and operational planning forums.

Example activities in each of these five intervention domains are presented on the next page.

5.1 Integrating Female Condom Promotion with Existing Services and Programs

Illustrative Channel Mix	Intended Audiences	Purpose
Clinic-based services—e.g., RMNCH, and HIV testing, care, treatment and/or support services **Community-based health and support services and health education programs—**e.g., RMNCH and HIV interventions, and support groups for people living with HIV (PLWH)	Women in relationships Single women Male partners	• Give users a choice of male condoms and female condoms to increase overall condom uptake. • Expand contraceptive choice to include both male and female condoms. • Co-locate promotion with product distribution to facilitate trial, repeat use and regular use. • Promote female condoms at scale through public sector health facilities. • Use primary health care settings to reinforce positioning of female condom for dual protection and de-emphasize disease prevention. • Reach women and their partners together via counseling services—e.g., couples testing for HIV—and facilitate discussion of fertility preferences. • Promote female condoms for STI/HIV prevention through one-on-one counseling, as part of HIV services, and through PLWH networks. • Give women and couples the chance to handle female condoms, receive education, practice insertion on pelvic models and ask questions to trained providers. • Through routine follow-up sessions, support new users to overcome any difficulties they are experiencing. • Provide negotiation skills training to reinforce competency with product itself. • Ensure continuity of support to help new users through difficult trial periods and motivate ongoing use.
Outreach programs targeting key populations at risk	Female sex workers	• Recognize stigma that prevents female sex workers accessing female condoms via mainstream channels. • Integrate commodity distribution with female condom skills and safe sex negotiation skills training. • Ensure continuity of support during critical trial period for a coitus dependent audience.
Community mobilization initiatives, particularly those focusing on women's empowerment and gender and relationship norms—e.g., community consultations, interactive theater, videos that stimulate dialogue **Life skills programs,** particularly those teaching relationship, communication and/or negotiation skills to women or couples—e.g., Stepping Stones **Social marketing programs and public sector male condom distribution networks**	Women in relationships Single women Male partners	• Address harmful social, gender and relationship norms, and cultivate healthier norms. • Engage communities, families and couples in dialogue on gender, including gender roles, women's health and HIV transmission. • Promote discussion of fertility preferences between couples as a healthy relationship norm. • Foster social change that increases women's ability to negotiate safe sex. • Integrate female condom skills training with life skills programs. • Give users a choice of male and female condoms to increase overall uptake. • Reinforce female condom positioning as a complement or alternative to the male condom. • Utilize existing sales and IPC skillsets of condom distribution agents.

5.2 Creating Awareness and Acceptability		
Illustrative Channel Mix	**Intended Audiences**	**Purpose**
IPC Female condom-specific IPC activities—e.g., one-on-one or small group activities on university campuses, at workplaces, churches, youth groups	Women in relationships Single women Male partners	• Give women and couples the chance to handle female condoms, receive instructions, practice insertion on pelvic models and discuss questions and/or difficulties with trained outreach workers. • Provide negotiation skills training to reinforce users' competency with the product. • Ensure continuity of support to help new users through difficult trial periods and motivate ongoing use. • Direct audience to female condom distribution outlets.
Community-based EE events, both health and non-health related—e.g., community events, health fairs, roadshows on college campuses, marketplace female condom demos		• Reach large audiences at single events. • Use role models—either community or public figures—to support female condom initiatives. • Increase general awareness and social acceptance of female condoms, fostering a more enabling environment for women to initiate discussion of female condoms with male partners. • Direct audience to female condom distribution outlets.
Mass media promotion *Low-budget options:* e.g., radio call-in shows, sponsored radio shows, product / message placement in media shows or reporting *High-budget options:* e.g., Multi-media campaigns using radio, television, print media, billboards, text messaging	All	• Create widespread awareness and acceptability within both primary and influencing audiences. • Prepare the ground for other channels. • Publicize access points, campaigns and events. • Create positive perceptions based on product attributes.
Media engagement and mass media reporting— e.g., Media workshops, media training events, press releases, outreach to journalists; print, broadcast and online coverage	Journalists All intended users	• Generate media coverage to create awareness of female condoms. • Counter any existing negative perceptions of female condoms among journalists. • Create positive perceptions of female condoms among the media and their audiences. • Create conducive conditions for other demand generation activities by raising general awareness. • Create widespread awareness and acceptability within both primary and influencing audiences. • Publicize access points, campaigns and events.
Social media and websites	All	• Create widespread awareness and acceptability within both primary and influencing audiences. • Create positive perceptions based on product attributes. • Use role models to support female condom initiatives. • Publicize local events and female condom distribution points. • Allow audiences to select the content they receive, including detailed content. • Make training, programming and other tools more widely available at low cost. • Target younger and urban/peri-urban users.

5.3 Leveraging the Private Sector		
Illustrative Channel Mix	**Intended Audiences**	**Purpose**
Traditional condom outlets—e.g., pharmacies, grocery stores	Women in relationships Single women Male partners Female sex workers	• Increase product and brand awareness and create positive associations—e.g., family planning, sexual pleasure—through visible point of sale promotion. • Promote alternative female condom products to those distributed through free channels to stimulate interest in the category as a whole. • Train pharmacy staff to demonstrate and promote female condoms.
Private health care providers	Women in relationships Single women Male partners	• See above, clinic based services. • Target women and/or couples from higher socio-economic backgrounds.
Non-traditional condom outlets (targeting general population audience segments)—e.g., hair salons, barber shops		• Opportunity to promote female condoms in female-friendly settings where there is time for instruction, negotiation skills training and dialogue. • Option of free or for sale female condoms. • Point-of-sale promotion benefits category as a whole. • Male-friendly outlets, such as barbershops, can be used to increase male awareness and acceptance.
Non-traditional outlets (targeting key populations at risk)—e.g., bars, nightclubs, brothels, hotels, motels, guest houses, late night stores, taxi/moto-taxi stands	Single women Male partners Female sex workers	• Make female condoms available close to where high-risk sex acts occur. • Complement outreach programs targeting female sex workers with venue-based promotion and distribution that reaches clients and high-risk women who are not sex workers, but engage in casual and/or transactional sex.

5.4 Training Health Providers and Health Educators		
Illustrative Channel Mix	**Intended Audiences**	**Purpose**
Government and NGO training programs for nurses, lay counselors, community health workers and health promoters—e.g., policies, guidelines, curricula, manuals and materials, rollout planning, delivery, support and monitoring	Health providers and health educators	• Ensure consistency of messaging. • Change / shape behavior and attitudes. • Equip audience with knowledge, skills and competencies to promote female condoms effectively. • Combat negative product perceptions. • Create enthusiasm and momentum for distribution and promotion, at scale and at grassroots level.

5.5 Engaging Decision Makers		
Illustrative Channel Mix	**Intended Audiences**	**Purpose**
Sensitization meetings, presentations and workshops at all levels, i.e., national to community	Stakeholders	• Target key focal points who can cascade information. • Sensitize leadership and key teams within intended organizational units—e.g., of MOHs. • Garner support for female condom programming. • Recruit champions.
Participation in **technical working groups—**e.g., SBCC, HIV, RMNCH, gender and women's empowerment		• Ensure that female condoms are on the right agendas. • Garner support and recruit champions. • Draw on technical expertise of membership.
Participation in **health sector forums** for policy, strategy and operational planning		• Integrate female condom program strategy with national planning cycles. • Garner support and recruit champions.

Step 6: Plan for Monitoring and Evaluation (M&E)

Refer to page 22 for supporting guidance on this step as well as "Step 6" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/ch-step5/) for further resources.

The table below presents an example M&E framework for female condom demand generation interventions:

Hierarchy of Objectives	**Performance indicators** *Disaggregated by intended audience, gender, age and partner type/ marital status as appropriate*
Health Impact	Source: National surveys, e.g., Demographic and Health Surveys (DHS); Multiple Indicator Cluster Surveys (MICS)
Reduce maternal mortality. (MDG 5.A)	Maternal mortality ratio (MDG indicator 5.1)
Increase contraceptive prevalence. (MDG 5.B)	Contraceptive prevalence rate (MDG indicator 5.6)
Halt the spread of HIV/AIDS. (MDG 6.A)	• HIV prevalence (MDG indicator 6.1) • Use of any condom at last high-risk sex (sex with a non-marital, non-cohabiting partner). (MDG indicator 6.2) • Use of any condom at last sex, by respondents with more than one sexual partner in the last 12 months. (UNGASS indicator 17)
Program Outcome—Female Condom Use	Source: Program-specific surveys of audiences and/or geographical areas targeted by demand creation interventions
Female condom programs contribute to an increased number of protected sex acts by either male or female condoms.	Percent of target audience reporting use at last sex of a) any condom, b) male condom, or c) female condom.
Female condom programs decrease the number of unprotected, high-risk sex acts.	Percent of target audience reporting use at last sex with non-marital, non-cohabiting partner of a) any condom, b) male condom or c) female condom.
Demand creation interventions increase demand for female condoms.	• Percent of target audience who report regular use of female condoms as part of their method mix (for contraception and STI/ HIV prevention). • Percent of target audience who report female condom use as a preferred contraceptive.
Intermediate Outcome—Increased Access to Female Condoms	Source: Program-specific surveys, unless indicated
Penetration of female condom has increased.	Percent of potential female condom outlets selling the female condom, by type of outlet.
Quality of coverage has increased.	Percent geographic areas where female condoms are available and where additional minimum standards of quality are present.
Women and men believe that there is ample opportunity to obtain female condoms.	Percent of target audience who agree that female condoms are readily available.
More organizations integrate female condoms into their programs.	Number of organizations actively programming female condoms, by type of organization and/or type of intervention. [Source: Routine program data]

Intermediate Outcome—Increased Ability to Use Female Condoms	Source: Program-specific surveys
More women and men use the female condom correctly.	• Percent of target audience who report that they know how to use the female condom correctly. • Percent of target audience who are able to correctly demonstrate female condom use on a model.
More women and men are able to convince their partners to use female condoms.	Percent of target audience who report that they are able to convince their partner to use female condoms a) for family planning, b) for dual protection and c) for STI/HIV prevention.
More women and men accept initiation of female condom use by their partner.	Percent of target audience who report that initiation of female condom use by their partner is acceptable a) for family planning, b) for dual protection and c) for STI/HIV prevention.
Intermediate Outcome—Increased Motivation to Use Female Condoms	Source: Program-specific surveys
Women and men believe in the efficacy of female condoms.	Percent of target audience who agree that female condoms provide effective protection against a) unplanned pregnancy b) STIs c) HIV d) all (dual protection).
Women and men hold positive perceptions of the female condom.	Percent of target audience who agree with specific positive attributes of female condoms, e.g., they are easy, comfortable, convenient to use; they do not reduce sexual pleasure for users and male partners.
There is a supportive environment for female condom use.	• Percent of target audience who report that female condom use is acceptable in their community, by relationship status and type of use. • Percent of target audience who agree that female condom use is acceptable.
Activities/Outputs	Source: Program-specific surveys, unless indicated
Availability of female condoms increases.	• Number of female condoms distributed freely; Number of female condoms sold. • Number of active distribution or sales outlets, by type of outlet: new outlets; total outlets.
More people are aware of the female condom and how to use it.	• Number of people reached with IPC activities that include female condom skills and negotiation training, by target audience. • Number of support materials distributed, by type of material and target audience. • Number of community mobilization activities conducted, by type of activity. • Number of media spots produced and aired, by message and channel. • Percent of target audience exposed to interventions. [Source: Program-specific surveys] • Percent of target audience who recall key messages. [Source: Program-specific surveys]
More people are skilled in female condom promotion.	Number of people trained in female condom promotion, by cadre.
More organizations know the female condom and how to program it.	• Number of advocacy sessions held, by influencing audience. • Number of organizations trained in female condom and comprehensive condom programming, by sector.

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