ASSESSING THE POTENTIAL OF MPTS IN UGANDA, NIGERIA AND SOUTH AFRICA

PREPARED FOR LUT VAN DAMME, BMGF | QUANT RESULTS 01st August 2014
THE RESEARCH OVERALL
Assessing the potential of MPTs in South Africa, Uganda and Nigeria

This research had 2 phases...

1. Qualitative Phase
   Presented in March

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

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

   Via
   - Women: 90 minutes IDIs and 120 minutes FGDs
   - Men: 60 minute IDIs
   - HCPs: 60 minute IDIs
   - Executives: 45 minute IDIs

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

2. Quantitative Phase

   We quantitatively surveyed 1,722 women

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

   Via
   - 60 minute interviews

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

Note: Both phases of the research received ethical approval from the relevant regulatory bodies in each country
THERE ARE 2 MAJOR OBJECTIVES FOR THIS RESEARCH

Part 1
To understand women in South Africa, Uganda and Nigeria in relation to sexual behavior, contraceptives and HIV
- Who Women are? What do their lives look like?
- What is their sexual behavior like?
- How do they feel about Pregnancy & Contraceptives? What are they aware of, what do they use? How do they learn about them? Do they feel at risk of getting pregnant?
- How do they feel about HIV Prevention & Testing? What are they aware of, what do they use? Are they getting tested? What about their partner? Do they feel at risk of getting HIV/STI?

Part 2
To gauge what the level of acceptability is for the 4 MPTs
- How acceptable is the concept of the MPT? & HIV Testing?
- Which is most acceptable?
- What is driving acceptability for each MPT?
- Do certain MPTs resonate more with certain groups of women? Who?
- What is the acceptability of side effects associated with some of the MPTs?
- The ring – changes/improvements
- What is the likely uptake of the MPTs?
- Commercial perspective of MPTs

Important note: this is an acceptability study not a forecast or segmentation
OUR KEY TAKE-OUTS WERE...

- There is universal acceptance of the concept of an MPT
- Women both need and want dual protection
- To be empowered and to be safe
- No one MPT form is ideal
- Each MPT form has unique features, which appeals to different women and resonates to women’s varying lifestyles or life stages, so one MPT will not be enough
- Women’s lifestyles are not uniform; there is a need for options
- The strategic intent of the MPTs is to reduce the HIV infection rate
- Therefore, it will be important to support those MPT forms which answers women’s needs, this may demand further investment and development as equally each MPT has unique features which are unappealing to women
### OUT OF ALL THE MPTS, SOME WILL REQUIRE MORE WORK IN ORDER TO ENSURE ADOPTION

<table>
<thead>
<tr>
<th>Resonance</th>
<th>Deployment</th>
<th>Barriers to be addressed</th>
<th>Key Maxims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INJECTABLE</strong></td>
<td>High</td>
<td>Medium</td>
<td>Low - Providers</td>
</tr>
<tr>
<td><strong>IMPLANT TYPE DEVICE</strong></td>
<td>High</td>
<td>Medium</td>
<td>Low - Providers</td>
</tr>
<tr>
<td><strong>INTRA-VAGINAL FILM</strong></td>
<td>Medium</td>
<td>Low</td>
<td>Medium-High - Education, misuse, trust</td>
</tr>
<tr>
<td><strong>INTRA-VAGINAL RING</strong></td>
<td>Low</td>
<td>Low</td>
<td>Medium-High - Education, design, trust, use</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY
WHAT IT MEANS FOR WOMEN

PART 1 – The Women

Answering the major objectives we found that...

- There are central differences in a woman’s experiences and daily life by country – relationships, families, education & environment
  - Women in South Africa are mainly single mothers not living with their partner, compared to women in Uganda and Nigeria who, if they have families will be married and living with their partner.
- Factors such as relationships, motherhood and environment impact sexual behavior, needs for contraceptives and uses of them
  - Reliance on modern contraceptives is greater in South Africa (male condom & injection). This varies in Uganda (male condom – low use, injection, and dispersed usage of other methods natural and OCPs, ECPs), and is low in Nigeria (male condom, followed by withdrawal, timing and ECPs)
- Strengths of interpersonal relationships and of healthcare system drive information sources, awareness and then use of contraceptives
  - SA – low partner influence; high healthcare system interaction
  - Uganda – higher partner influence; mid-healthcare system interaction
  - Nigeria – high partner influence; low HC system
- Perceptions of risk of pregnancy and HIV infection is influenced by relationships and environment
PART 2 – The MPTs

Answering the major objectives we found that...

- The concept of an MPT is desired by all women
- HIV testing is NOT a barrier for two thirds of women, and for some a 3-monthly testing is burdensome (Nigeria)
- Not one MPT is accepted by a majority of women. Overall, the implant is most acceptable, as well as the injection. The Film has a more specific coverage but fewer women accept it. The ring is the least acceptable MPT. There needs to be more than one MPT available.
- MPTs cover different situations and women
  - Implant: broadest coverage: married, mothers
  - Injection: broad coverage: married, mothers
  - Film: specific coverage: younger, more infrequent sexers
  - Ring: minimal coverage: mix and less defined
- MPTs such as the Implant and the Film have clear places in terms of duration and administration. The Ring does not have such a clear definition
- When thinking about acceptability of MPTs women are driven more by: ease of use, administration, size and appearance, prevention level and side effects are not as influential, however this comes with usage. In terms of side effects, women commonly agree that Diarrhoea and Migraines are least acceptable side effects for contraceptive & Anti Viral. The majority of side effects related to the Film and Ring are unacceptable especially infections.
- The implant and the injection will have the quickest and highest uptake
What does it mean?
5 CONCLUSIONS FROM THE RESEARCH

Answering the major objectives we found that...

1. High unmet need for contraception and HIV prevention due to poor adherence with methods and lack of trust with partner’s faithfulness

2. Motherhood, relationship status and environmental factors are the 3 key influences on sexual behavior, contraception usage and HIV prevention

3. There is universal acceptance of the concept of an MPT however, this does not translate into universal or automatic acceptance of any one form; options are needed in order to optimize coverage

4. Despite the differences in experience, drivers affecting acceptability of MPTs are very similar: ease of use, administration, appearance and duration. The majority of women want a long-term HCP-administered contraceptive; however there are women, in Nigeria in particular, who want an on-demand, self-administered contraceptive

5. The implant** and injection will be accepted by more women (they are long-term, HCP-administered protection) than the Film (on-demand self-administered protection). The ring has the lowest acceptability and is not aligned with any of the key acceptability drivers

** The implant profile specified 5-year contraceptive coverage and 6-month HIV protection coverage, versus 3-month contraceptive and HIV protection coverage by the injections. If the HIV protection coverage for the implant is only clinically possible for 2-3 months, this would likely result in a lower level of acceptability than measured vis-à-vis the injections; however, acceptability would still likely be higher for the implant than for the injections due to the long-term contraceptive coverage.
Making decisions

There are multiple criterion to take into account when making decisions on the MPTs – acceptability is one part of a wider set of answers ...

Environment  
- Contraceptive need
- Culture
- HIV prevalence

Situations
- Uptake
- Education required

MPT attributes
- Side effect profile
- Minimum acceptable efficacy
- Likelihood to succeed clinically
- Time to market
- Regulatory Status
- Cost of Development

Situations
- Communication required
- Support of govt.
- Acceptability
- Current contraceptive use
- Infection rate
- Healthcare system strength
WHAT ARE THE IMPLICATIONS FOR WOMEN?
# IMPLICATIONS

## WHAT IT MEANS FOR WOMEN

<table>
<thead>
<tr>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who you are</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- It is more common to be a mother, and single</td>
<td>- Women tend to be either:</td>
<td>- If you are under 18 yrs old you are more likely to be single, studying and not yet living with a partner</td>
</tr>
<tr>
<td>- More likely to be unemployed but looking for work</td>
<td>- Married, living with partner and have children if you are over 26 yrs old (trend: the older the more children) and if you're not working you are a homemaker</td>
<td>- You are likely to be married by the time you are 31 yrs old and live with their partner</td>
</tr>
<tr>
<td>- Closer to meeting your desired number of children</td>
<td>- Single (but with bf/partner), a student, living at home, with no child if you are under 25 yrs old</td>
<td>- Desire fewer years between children</td>
</tr>
<tr>
<td>- Live without partner (but at home with your family and extended family)</td>
<td>- Desire a large family, but in reality has more</td>
<td>- Despite having fewer children than Ugandan counterparts, end up having more children than desired</td>
</tr>
<tr>
<td><strong>Sexual Behavior</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Will have had more sexual partners</td>
<td>- Less sexually active if younger</td>
<td>- Like in Uganda, younger women are not as sexually active as those married and living with partner</td>
</tr>
<tr>
<td>- Have sex more frequently</td>
<td>- More sexually active and talk about sex if you are married and living with partner</td>
<td>- May or may not be long term, but will have only one sexual partner</td>
</tr>
<tr>
<td>- May talk to partner about sex</td>
<td>- May be in long term monogamous relationship with 1 sexual partner</td>
<td>- Unlikely to engage in sexual acts (anal, oral or dry sex)</td>
</tr>
<tr>
<td>- Do not engage in anal sex, more may engage in oral sex, and split on dry sex</td>
<td>- Do not engage in anal or oral sex and most do not engage in dry sex</td>
<td>- Practice faithfulness, however partner may not</td>
</tr>
<tr>
<td>- Probably faithful, but unsure of your partner’s faithfulness</td>
<td>- Practice faithfulness, however partner may not</td>
<td></td>
</tr>
</tbody>
</table>
IMPLICATIONS
WHAT IT MEANS FOR WOMEN

South Africa
Pregnancy & Contraceptives

Source
- Greater interaction with healthcare world, namely due to being a mother and for those using the injection – salient source of information (mostly nurses)
- Partner not a source of information

Use
- Either using male condom or injection
- Get contraceptives at no cost
- May talk to partner about sex and contraceptives
- Use condoms inconsistently
- Probably find it difficult to negotiate condom & contraceptive use

Risk
- More likely not to feel at risk or unsure of getting pregnant

Contraceptive preference
- Would prefer a long-acting contraceptive administered by HCP

Uganda

Source
- Interacting with the nurses for hormonal contraceptives, when a mother, and using the injection
- Friends important source of information, partners for withdrawal and condoms

Use
- Most likely to use condoms, then injection and to a lesser degree natural methods i.e. withdrawal
- Mostly self-pay for contraceptives
- More likely to talk to partner, however if married and living with partner may find it hard to negotiate
- Will not use condoms consistently

Risk
- More likely not to feel at risk of becoming pregnant

Contraceptive preference
- Overall preference for long-acting and HCP administered

Nigeria

Source
- Friends is a critical for information
- Partner more relevant - withdrawal
- Reduced interaction with HCPs

Use
- Would either use male condoms, or natural method
- Most likely talk to partner
- Prefer condoms if not married and not living with partner
- Will not use condoms consistently if married and living with partner
- If married, will find difficulty in negotiating condom and contraceptive use
- Partner will pay for condoms, self-paying for ECPs and OCPs

Risk
- Perceived risk of pregnancy depending on environment

Contraceptive preference
- Lower overall preference for long-acting HCP administration.
## IMPLICATIONS

### WHAT IT MEANS FOR WOMEN

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<th>South Africa</th>
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<tbody>
<tr>
<td>HIV Prevention &amp; Testing</td>
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</tr>
</tbody>
</table>

- **South Africa**
  - Condoms are main prevention method
  - Level of uncertainty about risk of being infected with HIV/STI
  - Will talk to your partner about HIV testing to some degree
  - Varying concern for pregnancy depending on their environment
  - Would have been tested for HIV - 14.8 months ago, just to know their status at a government hospital or health centre
  - May know partner HIV status (45%). However less likely to know they have been tested (~40%)
  - Information from nurses on condoms, and family and friends for natural methods
  - Do not share personal objects

- **Uganda**
  - Faithfulness and then male condoms are main prevention methods
  - More likely to feel at risk of being infected with an STI or HIV
  - Talk to partner about HIV and STI prevention
  - More concern about HIV than pregnancy
  - Would have been tested for HIV – 6.7 months ago, just to know their status at a government hospital
  - You may know your partner HIV status (50%), and more likely to know that your partner has been tested (~64%)
  - A mixture of HCP information (male condoms), local education and organisations like church (male condoms, abstinence and faithfulness) and friends (faithfulness and abstinence)
  - Do not share personal objects

- **Nigeria**
  - Male condom (main) then faithfulness methods of prevention
  - Unsure of risk of being infected with HIV/STI – if married and living with will feel less at risk
  - Talk to partner about HIV/STI
  - Varying concern for pregnancy – based on their environment and age
  - Less likely to have tested, if tested – 9.4 months ago, in a government hospital, just to know their status
  - If not tested (30%), did not think to check, do not think they have HIV, or too scared. Will probably know where to go and get a test
  - Less likely to know partner status.
  - Biggest source of information – friends (condoms) mother (abstinence & faithfulness)
  - Probably will not share objects

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Women are at risk of having unwanted pregnancies and contracting HIV:
- Not everyone is using the male condom (most often used in the past three months South Africa 50%, Uganda 20% and Nigeria 54%). On top of this many women admit condoms are not used consistently (South Africa 64%, Uganda 81% and Nigeria 73%).

The level use of contraceptives and HIV prevention is the result of the interplay of women’s relationships, motherhood and environment.

**Contraceptives and MPTs must be relevant within this mix and pertinent situations in women’s lives**
KEY TAKE-OUTS

Assessing the potential of MPTs in South Africa, Uganda and Nigeria
## MPTs: Key Take-outs

### The Injection

### Positioning & usage

<table>
<thead>
<tr>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>If all available: 27%</td>
<td>If all available: 35%*</td>
<td>If all available: 20%</td>
</tr>
<tr>
<td>If only one available: 77%</td>
<td>If only one available: 81%</td>
<td>If only one available: 49%</td>
</tr>
</tbody>
</table>

### Major drivers for usage & preference

<table>
<thead>
<tr>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Duration: 42%</td>
<td>Good Duration: 47%</td>
<td>Do not like inserting into vagina: 54%*</td>
</tr>
<tr>
<td>Trust health facilities: 44%*</td>
<td>Easy to use: 41%*</td>
<td>Good Duration: 33%</td>
</tr>
<tr>
<td>Dual protection: 32%</td>
<td>Do not like inserting into vagina: 30%</td>
<td>Don’t have to worry: 32%*</td>
</tr>
<tr>
<td>It is discrete: 30%*</td>
<td>Dual protection: 15%</td>
<td></td>
</tr>
</tbody>
</table>

### Which women would use it

<table>
<thead>
<tr>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single women, who are mothers</td>
<td>Married / living with partners women</td>
<td>Employed women</td>
</tr>
<tr>
<td>Unmarried</td>
<td>Unemployed but looking for work</td>
<td>Married/ living with partners</td>
</tr>
<tr>
<td>Women not living with mother</td>
<td>Mothers and to a lesser extent mothers-to-be</td>
<td>High impact on employed women</td>
</tr>
<tr>
<td>Women having frequent sexual intercourses</td>
<td>Women in rural settings</td>
<td>Mothers and currently unsure about wanting more children in the future.</td>
</tr>
<tr>
<td>Women come into contact with the healthcare world &amp; contraceptive methods / antenatal services</td>
<td>Homemakers</td>
<td>Don’t like to use intra-vaginal methods</td>
</tr>
<tr>
<td>Women whose partners dislike using condoms</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*I = significantly more than other countries*
## MPTs: Key Take-outs

### The Film

<table>
<thead>
<tr>
<th>Positioning &amp; usage</th>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ If all available: <strong>16%</strong></td>
<td>▪ If all available: <strong>19%</strong></td>
<td>▪ If all available: <strong>24%</strong></td>
<td></td>
</tr>
<tr>
<td>▪ If only one available: <strong>59%</strong></td>
<td>▪ If only one available: <strong>67%</strong>*</td>
<td>▪ If only one available: <strong>52%</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Major drivers for usage & preference

<table>
<thead>
<tr>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Easy to use: <strong>43%</strong></td>
<td>▪ Easy to use: <strong>50%</strong></td>
<td>▪ I don’t have sex that often: <strong>36%</strong>*</td>
</tr>
<tr>
<td>▪ Good duration: <strong>29%</strong></td>
<td>▪ It is discrete: <strong>25%</strong></td>
<td>▪ Dual protection: <strong>31%</strong></td>
</tr>
<tr>
<td>▪ Do not like injections: <strong>29%</strong></td>
<td>▪ I don’t have sex that often: <strong>23%</strong></td>
<td>▪ Do not like injections: <strong>27%</strong></td>
</tr>
</tbody>
</table>

### Which women would use it

<table>
<thead>
<tr>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Younger women (15-17yrs)</td>
<td>▪ Women (15-17yrs)</td>
<td>▪ Young women (15-17yrs).</td>
</tr>
<tr>
<td>▪ Women who are not mothers</td>
<td>▪ Women in education</td>
<td>▪ Women in education</td>
</tr>
<tr>
<td>▪ Women in urban setting</td>
<td>▪ Women in a relationship but are not married or living with the partner</td>
<td>▪ Unmarried no children</td>
</tr>
<tr>
<td>▪ Women who have casual sexual partners</td>
<td>▪ Having infrequent sex</td>
<td>▪ Having infrequent sex</td>
</tr>
<tr>
<td>▪ Women who dislike injections / other products</td>
<td>▪ Women in urban settings</td>
<td>▪ In long-term and/or monogamous relationship but not living with partners</td>
</tr>
<tr>
<td>▪ Women who find it difficult to negotiate condom use</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* = significantly more than other countries

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## MPTs: Key Take-outs

### The Ring

<table>
<thead>
<tr>
<th>Positioning &amp; usage</th>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>If all available: 10%</td>
<td>If all available: 7%</td>
<td>If all available: 9%</td>
<td></td>
</tr>
<tr>
<td>If only one available: 35%</td>
<td>If only one available: 48%*</td>
<td>If only one available: 20%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Major drivers for usage &amp; preference</th>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not like injections: 31%</td>
<td>Ease of use: 40%</td>
<td>Do not like injections: 44%</td>
<td></td>
</tr>
<tr>
<td>Duration: 31%</td>
<td>Duration: 23%</td>
<td>I don’t like other products: 35%</td>
<td></td>
</tr>
<tr>
<td>Dual protection: 29%</td>
<td>Can remove it: 21%</td>
<td>Duration: 31%</td>
<td></td>
</tr>
<tr>
<td>Trust healthcare facilities: 29%*</td>
<td></td>
<td>I may want to get pregnant: 25%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which women would use it</th>
<th>South Africa</th>
<th>Uganda</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals to rural women.</td>
<td>Appeals to rural women.</td>
<td>Appeals to rural women.</td>
<td></td>
</tr>
<tr>
<td>Women who do not like injections</td>
<td>Women in rural settings</td>
<td>Women who do not like injections</td>
<td></td>
</tr>
<tr>
<td>Women who have sex with only 1 sexual partner</td>
<td>Women who have no children currently but would like to conceive in the future</td>
<td>Unemployed women not seeking work and women with high frequency of sexual intercourse</td>
<td></td>
</tr>
<tr>
<td>Women who may favour storage of the product at home</td>
<td>Also some women not living with their partner(s)</td>
<td>Women without children may not want a child in the future.</td>
<td></td>
</tr>
<tr>
<td>Married and may need to be prepared to have sex with their partner</td>
<td></td>
<td>Also some mothers who want to space further children</td>
<td></td>
</tr>
</tbody>
</table>

* = significantly more than other countries

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WHAT ARE THE IMPLICATIONS FOR MPTs?

Assessing the potential of MPTs in South Africa, Uganda and Nigeria
MPTs: Implications for each country

South Africa

- Current contraceptive use predominately: male condom (52%) injection (36%*)
- Majority of women are single mothers (74%)
- Where motherhood activates injection usage (79%) at no cost
- Information sources mainly: Healthcare world and friends
- Inconsistent condom use (two thirds of women)
- Majority think they are at risk of HIV (61%)

- Universal acceptance of MPT: quickest and greatest uptake
- Most preferred MPT: Implant
  - If all available: 46%
  - If only one available: 82%
  - Use Top2box: 65%

Uganda

- Current contraceptive use: injection (29%) and male condom (24%) and dispersed usage across natural methods, OCPs and ECPs
- Women are either married or single with a bf/partner – married women have more sex and use condoms inconsistently (80%)
- Information sources mainly: friends, nurses where relevant, and partner
- Majority think they are at risk of HIV (67%)

- Universal acceptance of MPT – medium uptake of MPTs
- Most preferred MPT: Implant & Injection
  - If all available: 35%, 35%*
  - If only one available: 79%, 81%
  - Use Top2box: 61%, 67%

Nigeria

- Current contraceptive use: male condom (57%) withdrawal (12%) Timing (7%) ECPs (7%)
- Older women are married, living with partner
- Inconsistent condom use (72%)
- Friends and partner influential sources of information – not HCPs
- Majority think they are at risk of HIV (66%)

- Universal acceptance of MPT – slowest of the 3 countries to uptake
- Most preferred MPT: Implant followed by Film & Injection
  - If all available: 44%, 24%, 20%
  - If only one available: 64%, 52%, 49%
  - Use Top2box: 61%, 43%, 46%

* = significantly more than other countries

Assessing the potential of MPTs in South Africa, Uganda and Nigeria
IMPLICATIONS FOR MPTS

The MPTs which fit into the dynamic set of influencers best are the:

1. Implant
2. Injection and
3. Film – specific women/situation

The Implant and Injection resonate more broadly, across situations and women’s life stages – whether a mother, or married and having to be prepared for sex.

The Film has a clear place for women i.e. infrequent sexers, not married, not mothers, young women.

The Ring has less resonance as its place is not as well defined.

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THANK YOU

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