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Preventing HIV Transmission in Intimate Partner Relationships

Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia

Proposed citation:
UNDP (2015). *Preventing HIV Transmission in Intimate Partner Relationships: Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia*. Bangkok, UNDP.

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Cover photo: Husband and wife both living with HIV, Thái Nguyên Province, Viet Nam, 2010. Steve McCurry/Magnum Photos.

Design: QUO Bangkok Co., Ltd.

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Preventing HIV Transmission in Intimate Partner Relationships

Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia

CONTENTS

FOREWORD

High levels of HIV transmission between intimate partners are characteristic of Asia's long-running HIV epidemics, where new infections are largely concentrated in key populations (people who inject drugs, sex workers and their clients, men who have sex with men, and transgender people) and their intimate sexual partners.

This report highlights the complex interactions among behavioural, social, and structural factors that influence how adult and young men and women from key populations and people in relationships where one partner is HIV positive negotiate safer sex and contraceptive choices. A range of factors make it difficult to reach intimate partners with information, services, and referrals. While resources and efforts must continue to be focused on preventing new infections among key populations, innovative strategies and approaches are needed to reach their intimate partners as well.

Taking into account local contexts and cultures, this report offers five high-impact strategies aimed specifically at preventing sexual and mother-to-child transmission of HIV within intimate partner relationships. These strategies draw on proven biomedical interventions, such as antiretroviral-related prevention; evidence-based social and behavioural prevention interventions; and structural interventions to promote an enabling environment. Report findings show that the most effective interventions take into account age and gender issues, are rights-based, and are developed in partnership with adult and adolescent key populations and people living with HIV.

Programmatic examples cited in the report demonstrate that these strategies do not require a significant reorientation of existing approaches and resources, or large-scale changes to national HIV programmes. Rather, prevention of intimate partner transmission of HIV can be addressed within strategies and programmes already implemented or planned, including national frameworks, policies and programmes for HIV, sexual and reproductive health, and gender equality, and grants including the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The intention of this report is to provide evidence-based guidance to policymakers in Asia so that national HIV responses give appropriate priority to prevention efforts among key populations and their intimate partners, as well as couples in serodiscordant relationships. Scaling up efforts to prevent intimate partner transmission of HIV will help countries to meet global targets that aim to halve sexual transmission of HIV, eliminate mother-to-child transmission, and reduce AIDS-related maternal deaths by 2015 as well as eliminate gender inequalities. UNDP, UNICEF and UNAIDS stand ready to support countries in taking forward the recommendations contained in this report.

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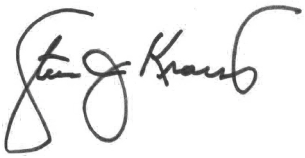

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ACKNOWLEDGEMENTS

This report was authored by Katy Pullen, an independent consultant with ten years' experience in the field of HIV and human rights in Asia and the Pacific. The initiative was conceptualized and overseen by Nashida Sattar, UNDP Bangkok Regional Hub; and Revati Chawla and Shirley Mark Prabhu, UNICEF East Asia and Pacific Regional Office, Bangkok, under the overall guidance of Nadia Rasheed (UNDP) and Wing-Sie Cheng (UNICEF). Editorial support was provided by John Tessitore and Andy Quan.

The report was prepared under the guidance of the Asia Pacific Interagency Task Team on Women, Girls, Gender Equality and HIV (IATT), which is comprised of representatives from regional UN agencies and civil society organizations, including regional networks of key populations and people living with HIV. It was initiated following a 2012 consultation in Lao PDR that sought to review evidence on interventions that address intimate partner transmission of HIV in South-East Asian epidemics. The meeting was hosted by the Lao Women's Union on behalf of the ASEAN Committee on Women, with support from the ASEAN Foundation, ASEAN Task Force on AIDS, and the Asia Pacific Interagency Task Team on Women, Girls, Gender Equality and HIV (IATT). The outcomes of this consultation led to joint recommendations adopted by the ASEAN Committee on Women and the ASEAN Task Force on AIDS to reduce intimate partner transmission of HIV within the region.

UNDP and UNICEF would like to thank the Reference Group for their support through the process and their contributions to the desk review and the substance of the report. The Reference Group included: Yogie Wirastra (representing both APCOM and ANPUD), Midnight Poonkasetwattana (APCOM), Kay Thi Win (APNSW) and Tracey Tully (APNSW), Jet Riparip (International HIV/AIDS Alliance), Thaw Zin Aye (YouthLEAD), Anh Vu Lieu (Youth Voices Count), Rose Koenders (Asia Pacific Alliance for Sexual and Reproductive Health and Rights), Khin Cho Win Htin and Ye Yu Shwe (HIV and AIDS Data Hub for Asia and the Pacific), Brianna Harrison (UNAIDS), Yuki Takemoto (UNAIDS), Amala Reddy (UNAIDS), Dr. Vladanka Andreeva (UNAIDS), Smriti Aryal (UNAIDS), Doriane Gillet (UNAIDS), Rebecca Nedelko (UNDP), Sangita Singh (UNDP), Justine Sass (UNESCO), Sahba Delshad (UNESCO), Juncal Plazaola Castano (UNFPA), Gabrielle Szabo (UNFPA), Dr. Annefrida Kisesa-Mkusa, (UNICEF), Bettina Schunter, (UNICEF), and Inthira Tirangkura (UN Women).

Special thanks to the UNAIDS Regional Support Team for Asia and the Pacific for reviewing draft versions of this report and providing detailed feedback. Particular thanks are due to Amala Reddy, Khin Cho Win Htin, and Ye Yu Shwe for their guidance and technical support related to data review and analysis.

LIST OF ACRONYMS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ANPUD	Asian Network of People who Use Drugs
APCOM	Asia Pacific Coalition on Male Sexual Health
APN+	Asia Pacific Network of People Living with HIV
APNSW	Asia Pacific Network of Sex Workers
APTN	Asia Pacific Transgender Network
ART	antiretroviral treatment
ARV	antiretrovirals
BCC	behaviour change communication
BSS	behavioural surveillance survey
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHTC	couples HIV testing and counselling
CRC	Convention on the Rights of the Child
ESCAP	Economic and Social Commission of Asia and the Pacific
GNP+	Global Network of People Living with HIV/AIDS
HIV	human immunodeficiency virus
IBBSS	integrated biological and behavioural surveillance survey
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social, and Cultural Rights
IDU	injecting drug user
IPT	intimate partner transmission (of HIV)
MCH	maternal and child health
MOT	mode of transmission
MSM	men who have sex with men
M&E	monitoring and evaluation
NSP	National Strategic Plan on HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PWID	people who inject drugs
SAARCLAW	South Asian Association for Regional Cooperation in Law
SEARO	WHO Regional Office for South-East Asia
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

EXECUTIVE SUMMARY

Why prevention of intimate partner transmission of HIV matters in Asia

High levels of intimate partner transmission of HIV are characteristic of long-running, concentrated epidemics in Asia. Although data shows substantial male-to-female intimate partner transmission rates in Asian countries with mature epidemics, there is also some evidence of HIV transmission from women to their intimate male partners. Yet few HIV prevention programmes with key populations (people who inject drugs, sex workers and their clients, men who have sex with men, and transgender people) integrate or include components to address this issue; fewer still have an explicit focus on intimate partner transmission. Prevention programmes that focus on serodiscordant couples (intimate relationships in which one partner is living with HIV and the other is not) also remain significantly underdeveloped in several countries.

This report provides policymakers and programmers with a framework of five strategies and associated recommendations for preventing intimate partner transmission of HIV in Asian settings, where new infections are concentrated in key populations and their intimate sexual partners.

The evidence base for intimate partner transmission of HIV

Surveillance data shows that in several of Asia's concentrated epidemics, the contribution of intimate partner transmission to the number of new adult HIV infections is significant. This includes Cambodia, China, India, Indonesia, Myanmar, Thailand and Viet Nam. Data also indicates that the majority of men living with HIV belong, or once belonged, to a key population group. Consequently, a significant number of women become infected as a result of their sexual relationships with men who are, or once were, engaged in high-risk behaviours. This calls for greater attention and investment in prevention programmes regarding men from key populations and their intimate partners. It also underscores the need for prevention interventions with serodiscordant couples.

HIV risk and vulnerability in intimate partner relationships in Asia

Key populations and people living with HIV can experience different types of intimate relationships – both same-sex and heterosexual – including but not limited to marriage, casual dating, and monogamous and non-monogamous intimacy. To date, regional efforts to address intimate partner transmission of HIV have focused on the vulnerabilities of female partners of men with high-risk behaviours. This review gives greater attention to the interplay of factors that affect sexual behaviour and decision-making among key populations and people living with HIV who know their status, including how they negotiate safer sex and contraceptive choices with their intimate partners. The result is a more comprehensive understanding of HIV risk and vulnerability in intimate partner relationships, providing the basis for more effective rights-based programming.

Why a combination prevention approach is needed

Based on the evidence reviewed, the most effective way to prevent intimate partner transmission of HIV in Asia is to adopt a 'combination prevention' approach. This involves the coordinated use of different types of HIV prevention activities that operate on many levels (i.e. behavioural, social, structural) to address HIV risk and vulnerability among men and women in their intimate partner relationships. Adopting this framework does not require a significant reorientation of existing approaches and resources. Nor does it require large-scale changes to national HIV programmes. UNDP and UNICEF instead encourage policymakers and programmers to reach out to the intimate partners of key populations and people living with HIV within their existing HIV prevention and treatment efforts.

Five high-impact strategies for reducing and preventing intimate partner transmission of HIV

HIV prevention efforts need to target investments in the right places. Based on the regional context, this review identifies five strategies to reduce and prevent intimate partner transmission of HIV that could have the greatest impact with limited resources.

STRATEGY 1: Ensure existing primary HIV prevention efforts with key populations also reach out to their intimate partners with information, referrals and services.

STRATEGY 2: Ensure that services that integrate HIV and sexual and reproductive health and rights (SRHR) reach both key populations and their intimate partners, building on existing HIV and SRHR programming.

STRATEGY 3: Use new, proven biomedical interventions (such as antiretroviral-related prevention) to prevent HIV transmission from HIV-positive individuals to their intimate partners.

STRATEGY 4: Increase the involvement of male intimate partners in integrated antenatal care (ANC), maternal and child health (MCH), and prevention of mother-to-child transmission of HIV (PMTCT) services.

STRATEGY 5: Reform laws and policies that hinder efforts to reach the intimate partners of key populations and people living with HIV with information and services.

GENDER EQUALITY AND HUMAN RIGHTS AS A CROSS-CUTTING APPROACH:

A gender equality and rights-based approach requires that interventions to prevent intimate partner transmission of HIV are implemented in a way that fosters human rights protection, reduces stigma and discrimination, and encourages the engagement of adult and adolescent key populations and people living with HIV.

Recommendations to policymakers, programmers and practitioners

For policymakers:

Provide the policy mandate and steer the national programme towards systems to strengthen data collection, triangulation and synthesis related to intimate partner transmission of HIV. These efforts can be supported by adopting a consistent national definition of intimate partner relationships which is integrated in data collection tools, by strengthening age and gender disaggregation of data on key populations, and through operational research on sexual risk behaviour and sexual decision-making among key populations and serodiscordant couples.

Include strategies to prevent intimate partner transmission of HIV in national HIV plans and funding applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria. This includes greater allocation of resources in national action plans and sectoral budgets and Global Fund programmes to interventions that reach out to the intimate partners of key populations and people living with HIV.

Harmonize national sexual and reproductive health (SRH) and HIV/sexually transmitted infection strategies and related health institutions, in order to expand outreach and coverage of services to key populations, people living with HIV, and their intimate partners.

Use national gender equality policies and plans of action to address the factors that increase HIV risk and vulnerability in intimate partner relationships. National gender equality action plans and policies can be entry points for identifying specific measures and resources to eliminate gender inequalities and gender-based abuse/violence experienced by male, female and transgender populations and by men, women, girls and boys living with HIV.

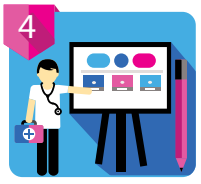
Review and reform laws and policies that hinder efforts to reach the intimate partners of key populations and people living with HIV with information and services. This includes reforming laws that criminalize the conduct of key populations and people living with HIV, and that require marriage or spousal consent to access HIV, SRHR and other related services. It can also mean the review and revision of consent policies to reduce age-related barriers to HIV and SRHR services and to empower providers to act in the best interest of adolescents.

For programmers and practitioners:

Strengthen data collection and strategic information as it relates to HIV risk and vulnerability in the context of intimate partner relationships, and use this to develop evidence-based interventions to prevent intimate partner transmission of HIV. This is relevant for those developing and implementing programmes at national, sub-national and community levels and may require additional data collection, further analysis of pre-existing data, operational research, or triangulation of information from studies and programmes with key populations and people living with HIV. This recommendation is also relevant to policymakers.

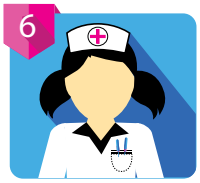
Expand HIV prevention strategies with key populations to include components to reach their intimate partners with information, referrals and services. This includes greater attention and allocation of resources to programmes that promote male responsibility for HIV prevention, empower women from key populations to protect themselves and their sexual partners, and extend service outreach to intimate partners.

Create demand as well as flexible delivery and supply for HIV/SRHR integrated services among adult and adolescent key populations and serodiscordant couples. Efforts should start with the integration of services (e.g. access to contraception, safe abortion and family planning) that are priorities for the community and relatively easy to implement, building on what already exists in terms of HIV and SRHR programming.



Train and sensitize health care workers to ensure that they have the skills and understanding to provide age and gender-appropriate services to key populations and people living with HIV as well as to their intimate partners, based on all persons' right to health, confidentiality and non-discrimination.

Work with communities and service providers to identify and overcome barriers to the access and utilization of ANC/MCH and PMTCT services among women from key populations and their intimate partners.



Expand access to couples HIV testing and counselling and to antiretroviral treatment for women and their intimate partners in ANC and MCH clinics.

Scale-up initiatives that increase male involvement in HIV testing during ANC and improve male participation in couples HIV testing and counselling.

Implement biomedical interventions, including ARV-related prevention, to prevent HIV transmission from HIV-positive individuals to their intimate partners.
Countries should refer to the most recent technical guidance from the World Health Organization. At the time of publication, this includes recommendations on ARV-related prevention contained in WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (August 2014). Such approaches must be underpinned by the principles of Positive Health, Dignity and Prevention. Accordingly, national protocols on ARV-related prevention should uphold principles related to the dignity and agency of people living with HIV to participate in the design and implementation of programmes and to make informed decisions about their health and lives.

1

Introduction

1.1 Context

Most countries in Asia are experiencing concentrated HIV epidemics, with new infections occurring primarily in key populations and among their immediate sexual partners. Prevention of intimate partner transmission of HIV should therefore be viewed as an essential component of comprehensive national HIV prevention strategies. However, establishing the evidence base for intimate partner transmission of HIV remains problematic. Incomplete data and assumptions, limitations in modelling around HIV incidence, and a lack of consistency in the terms used to define and describe this type of relationship all present challenges. These are compounded by the concern that a focus on intimate sexual partners (including spouses) may direct attention and resources away from populations that are most at risk of HIV infection and towards prevention efforts aimed at the general population. Such a shift would make little sense in the context of a concentrated epidemic. As a result, there can be reluctance to develop and implement prevention responses that address intimate partner transmission of HIV.

This is a critical problem given that the transmission of HIV to the intimate sexual partners of those currently or formerly at higher risk (e.g. clients of sex workers, men who have sex with men and people who inject drugs) has been shown to increase as concentrated epidemics mature in Asia. In countries with long-running concentrated epidemics, such as Cambodia, Myanmar and Thailand, it is estimated that approximately one-third of new HIV infections are occurring among people within intimate partner relationships.[1] Of those infected through heterosexual transmission in China, it is estimated that between one-quarter and one-third were infected through spousal sexual contact.[2] The primary risk factor for HIV among married women in India appears to be their spouses' involvement in extramarital or paid sex.[3] Intimate partner transmission also accounts for a significant proportion of new adult HIV infections in Indonesia and Viet Nam. Together, these six countries constitute the majority of the HIV disease burden in Asia. If the region is to meet the global commitments set out in the 2011 Political Declaration on HIV and AIDS and in the Millennium Development Goals, specific strategies to reduce and prevent intimate partner transmission of HIV must be integrated into existing HIV prevention, treatment, care and support programmes.

These strategies will only be effective if they are grounded in gender equality and human rights principles, and are guided by international norms and standards. The trajectory of HIV epidemics in Asia highlights the importance of human rights-based approaches and supportive legal environments to achieving positive health outcomes for all. Rights-based approaches can reduce vulnerability to HIV; help ensure that HIV prevention, treatment and care are accessible by those most at risk; and enable affected communities to participate in planning and implementing effective interventions. On the other hand, punitive laws – such as those that criminalize HIV transmission and exposure, sex between men, sex work and drug use – or legal environments that fail to protect the rights of adult and adolescent male, female and transgender persons[4] both act as major barriers to accessing HIV services and interventions. They reinforce stigma and discrimination, and hinder national responses to prevent HIV transmission, including transmission within intimate partner relationships.[5]

1 National Centre for HIV/AIDS, Dermatology, and STDs and partners (2011), *HIV Estimation and Projection 2011* (Cambodia: Phnom Penh); National AIDS Committee Thailand (2012), *Thailand Global AIDS Response Progress Report, 2012;* Gouws et al., "Focusing the HIV response through estimating major modes of HIV transmission: A multi-country analysis," *Sexually Transmitted Infections* 88 (2012): i76–85.

2 Ministry of Health, People's Republic of China/UNAIDS/WHO (2011), *Estimates for the HIV/AIDS Epidemic in China* (Beijing).

3 UNAIDS (2009), *HIV Transmission in Intimate Partner Relationships in India* (New Delhi).

4 For the purpose of this report, female-to-male transgender persons who sometimes call themselves trans-men, and male-to-female transgender persons who sometimes call themselves trans-women are referred to as transgender males and transgender females respectively. However, in their own lives, they may prefer to refer to themselves as female, male, third sex or by local terminology.

5 Based on UNDP Global Fund Partnership, *Human Rights and HIV*, at http://www.undp-globalfund-capacitydevelopment.org/home/cd-toolkit-for-hivaids,-tb-malaria-responses/enablers/2-key-human-rights-frameworks/human-rights-and-hiv.aspx.

1.2 Objectives and purpose of the review

This publication aims to assist policymakers and programme planners to understand and initiate strategies for preventing intimate partner transmission of HIV in Asia, where HIV epidemics remain largely concentrated among people who inject drugs, men who have sex with men, sex workers and transgender people. This includes more effective resource allocation to prevention programmes addressing key populations (including those in serodiscordant relationships) in national HIV plans, programmes and policies, including in Concept Notes submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The objectives of the review were threefold:

1 To assess intimate partner transmission of HIV in Asia

2 To identify the determinants of HIV risk and vulnerability relating to intimate partner transmission of HIV in the region

3 To identify high-impact, cost-effective strategies that can be used to prevent transmission of HIV between key populations and their intimate partners, including those who are in serodiscordant relationships.

1.3 Methodology

- **Review framework and methodology**

  This review used participatory, utilization-focused approaches[6] as well as gender analysis. The review methodology involved a structured review of academic and grey literature pertaining to HIV transmission within intimate partner relationships. A systematic search of electronic databases and consultation with programme experts were used to identify relevant publications. Findings from the structured review were synthesized, discussed with the Reference Group, and adjusted accordingly. The Reference Group members are listed in the Acknowledgements at the front of this report.

  As part of the data collection process, a list of key informants was developed in collaboration with regional networks of key populations, including APN+, APNSW, APTN, APCOM, ANPUD and YouthLEAD. The principles of voluntary participation, informed consent and anonymity were adhered to throughout the review process.

- **Data analysis and triangulation**

  Data collected through the various methods, tools and sources described above was separated, coded and differentiated between quantitative and qualitative, and checked for consistency and variability. Where possible, quantitative and qualitative data was formed into tables and analysed. Data was triangulated across sources and respondents, all of whom agreed to be quoted anonymously. This included data from interviews that were reviewed, analysed and compared for consistency and accuracy. Overall, a reasonable degree of consistency was found among the data sources. In the case of inconsistent data, possible reasons were investigated in order to enable reliable conclusions to be drawn from the assembled body of evidence.

1.4 Limitations of the review

The following limitations of the review are noted:

- National-level data collection tools often use different terms to describe an intimate partner relationship, making it harder to undertake cross-country analyses and take a regional view of the seriousness of intimate partner transmission of HIV as a mode of transmission.

[6] Utilization-focused approach is based on the principle that a review (and its findings) should be rated on its usefulness to its intended users. That is to say, reviews should be planned and conducted in ways that enhance the likely utilization of both the findings and of the process itself to inform decisions and improve implementation.

- There is a shortage of evaluated data specific to interventions that reduce intimate partner transmission of HIV in concentrated epidemics. Attempts have been made to gather and understand the information that exists within and beyond Asia, but there are inadequacies in the analysis presented, and these are noted in the report.
- Particular challenges were presented in synthesizing and comparing results of studies conducted with key populations or serodiscordant couples in a wide variety of contexts and using different approaches. For example, not all studies included easily comparable information on relevant issues, such as the association between an individual's HIV risk and vulnerability and their sexual behaviour with an intimate partner.
- The lack of information in many studies regarding the age of respondents or study participants made it difficult to disaggregate the analysis by this variable. Given that a considerable proportion of people living with HIV are young people under the age of 25, understanding their experience of dating relationships is critical to effective HIV prevention programming.

1.5 Definitions used in the review

- **Intimate partner relationship**

  The term 'intimate partner relationship' emerged in the discourse of intimate partner violence and has evolved over time to include different types of intimate relationships.[7] This has led to a more nuanced definition of this type of relationship by social scientists. For the purpose of this review, an intimate partner relationship can be a legal or common-law marriage or a dating relationship. Generally, a 'dating relationship' is defined as a romantic or intimate social relationship between two individuals. Factors that characterize a dating relationship can include the length of the relationship, the nature of the relationship, and the frequency of interaction between the two individuals. There is no minimum time requirement for a dating relationship to be considered an intimate partner relationship. In this review, a dating relationship does not include casual sexual encounters (i.e. where this is no expectation of an actual relationship) or transactional sexual relationships. Further, intimate partners may be of the same or opposite sex. Additionally, being an intimate partner does not require cohabitation.

- **Intimate partner transmission of HIV**

  For the purposes of this report, intimate partner transmission focuses on the sexual transmission of HIV within an intimate partner relationship (i.e. transmission via sharing needles is not included). The term 'intimate partner transmission' is used rather than 'spousal transmission' because intimate partners are not necessarily married.[8]

- **Key populations**

  The term 'key populations' or 'key populations at higher risk of exposure' refers to men, women, transgender people[9], and girls and boys most likely to be exposed to HIV or to transmit it.
  The engagement of key populations is critical to an effective HIV response, as these population groups are key to halting and reversing the epidemic in their countries. In all countries, key populations include people living with HIV. Defining the specific populations that are key to a country's HIV epidemic and response needs to be based on the epidemiological and social context.[10] In the concentrated epidemics found across Asia, sex workers and their clients, people who inject drugs, men who have sex with men, transgender persons, and seronegative partners in serodiscordant couples are at higher risk of exposure to HIV than other people. Evidence from the region also indicates that there is a strong link between various kinds of mobility and a heightened risk of HIV exposure.

[7] Gilfus, M. E., N. Trabold, P. O'Brien, and A. Fleck-Henderson, A. (2010), "Gender and intimate partner violence: Evaluating the evidence," *Journal of Social Work Education* 46.2: 246–263.

[8] The UNAIDS Terminology Guidelines, 'HIV transmission in intimate partner relationships' describes the transmission of HIV to people from their regular partners who inject drugs and/or have sex with other people, including with sex workers UNAIDS (2011), *Terminology Guidelines* (Geneva).

[9] Who may identify as male or female.

[10] Ibid.

- **Serodiscordant couples**

  HIV serodiscordant couples, in which one partner is HIV-positive and the other is HIV-negative, are increasingly recognized as a priority for HIV prevention in Asian countries. Using the World Health Organization (WHO) definition, 'couple' in this context refers to two persons in an ongoing sexual relationship; each of these persons is referred to as a 'partner' in the relationship. How individuals define their relationships varies considerably according to cultural and social contexts.[11] When it comes to HIV programming for serodiscordant couples, WHO recommends that policymakers and programmers should not prescribe the definition of couples who can benefit from HIV interventions.[12]

Challenges around key terms and definitions

Intimate partner relationships: National-level data collection tools such as behavioural surveys (e.g. behavioural surveillance surveys and integrated biological and behavioural surveillance surveys), voluntary confidential counselling and testing, antenatal care surveillance, and small sample surveys often use different terms to describe an intimate partner relationship, including 'married', 'spouse', 'regular partner', 'living with', 'stable relationship' and 'long-term partner'. Furthermore, many tools assume that a person has only one such partner. For youth, these ways of characterizing intimate sexual relationships can be even more problematic because the definition of an intimate partner – and the patterns of unsafe sex associated with such partnerships – are often different from that of the adult population.[13] Even in countries that analyse and report on intimate partner transmission of HIV, this type of relationship may be defined using different parameters. Some countries refer to 'spousal transmission', which usually denotes male-to-female HIV transmission in marital relationships. Other countries in the region refer to transmission within 'stable heterosexual partnerships', which encompasses a broader definition than marital relationships. Together, these variations make it harder to undertake cross-country analyses and to take a regional view of the seriousness of this mode of HIV transmission.

Serodiscordant couples: The term 'serodiscordant couple' or 'serodiscordant relationship' is often associated with the image of a monogamous heterosexual couple where one partner is living with HIV and the other partner is not. This is not always the case. In Asia's epidemic contexts, there exists a range of serodiscordant relationships that place an HIV-uninfected individual at risk of HIV infection from a partner who is living with HIV. These include relationships that are with members of the opposite sex or same sex in which one, both, or none of the partners are currently a member of a key population group. Yet studies and data on serodiscordant couples often focus on married heterosexual couples and do not always stratify results by populations at higher risk for HIV. Such limitations make it difficult to identify the range and interplay of factors that may influence the risk of HIV transmission in each of these types of serodiscordant relationships. While there is a greater body of research available looking at heterosexual serodiscordant couples in which the male partner is HIV-positive and from a key population group, the analysis presented in this report also draws on the handful of small-scale studies from the region that examine the intimate partner relationships of adolescents living with HIV, HIV-positive men who have sex with men, and HIV-positive female sex workers.

[11] World Health Organization (2012), *Guidance on couples HIV testing and counselling – including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for public health approach* (Geneva).

[12] Ibid. For instance, the principle for couples HIV testing and counseling (CHTC) should be that any persons who are in a sexual relationship and wish to test together and mutually disclose their results should be supported to receive this intervention. Health workers should support the decisions of partners to test together, irrespective of the length or stability of their relationship, and policymakers and implementers should ensure that services are inclusive and non-judgemental in order to maximize the uptake and impact of such interventions.

[13] Asia Pacific Interagency Task Team on Women, Girls, Gender Equality and HIV, *Report of the roundtable on data synthesis exercises to better understand the number of women at risk of HIV through intimate partner transmission* (Bangkok).

1.6 Data issues

Based on global surveillance guidelines, national HIV and AIDS surveillance systems in Asia are designed to monitor HIV infections among key populations: primarily sex workers, men who have sex with men, and people who inject drugs. Several countries in the region survey men in occupations that put them at higher behavioural risk of HIV infection as proxies for clients of female, transgender and/or male sex workers. This includes mobile populations (truck drivers, seafarers), among others. However, data from these routine biological and behavioural surveillance surveys often cannot be used to determine the extent and trend of intimate partner transmission. Why? Appropriate data is not collected, such as information on the proportion of key populations with intimate partners, frequency of sex, and the proportion of unsafe sexual or injecting practices between them. A few countries collect biological data on spousal transmission among serodiscordant heterosexual couples, generally at antenatal care (ANC) clinics. So, while models and tools are available that can be used to estimate HIV infections attributable to intimate partner transmission, data is limited or inadequate in most countries, not sophisticated enough to describe the epidemiology and risk behaviours required to calculate the dynamics and probability of HIV transmission from intimate partners.

BOX 1 CHALLENGES IN ESTIMATING THE NUMBER OF WOMEN AND MEN AT RISK OF HIV THROUGH THEIR INTIMATE PARTNER RELATIONSHIPS

Estimating the number of women and men at risk of HIV through intimate partner transmission is no easy task. The process of data collection and analysis would need to include:

1 Estimated population size of key populations and clients of sex workers.
2 Proportion of key populations (including clients of sex workers) who have intimate partners.
3 HIV prevalence in key populations (including clients of sex workers).

Information is also needed on factors and behaviours that are associated with HIV transmission in the context of intimate partner relationships. This includes information on:

- Unprotected sexual practices
- Unsafe injecting practices
- Associated STIs
- HIV subtypes
- Awareness of HIV status
- CD4 counts
- Adherence to antiretroviral treatment
- The level of enabling environment (including issues such as stigma, discrimination and violence, and access to HIV-related services, among others).

2 HIV risk and vulnerability in intimate partner relationships in Asia

2.1 Determinants of HIV risk and vulnerability

Research from the region highlights three types of factors that may shape the sexual risk behaviour of key populations and individuals living with HIV, as well as their choices about contraception with their intimate sexual partners. These are:

i) **Behavioural factors** (individual behaviours)

ii) **Social factors** (social context, culture, community)

iii) **Structural factors** (laws, policies, practices, environment, and other contexts that directly or indirectly affect an individual's options and behaviour)

Identifying these different factors – or *determinants* – and the way they interact to increase HIV risk and vulnerability is an important part of 'knowing your epidemic'. No single factor can fully explain the sexual risk behaviour of an individual. In the context of intimate partner transmission of HIV, different factors interact and affect how key populations negotiate this risk with their sexual partners.

2.2 Male partners who engage in high-risk behaviours

To date, efforts to address intimate partner transmission of HIV in the region have largely focused on the vulnerabilities of female intimate partners of men with high-risk behaviours. There has been less attention directed to understanding the determinants of HIV risk and vulnerability among male key populations and how this affects their sexual decision-making and behaviour with intimate partners. If countries in the region are to reduce intimate partner transmission of HIV, prevention efforts need to acknowledge that men's HIV risk, like that of women, can be heightened through gender and structural inequality.[14]

Male clients of sex workers

Male clients of sex workers remain the largest population at risk of HIV infection in Asia. Numerous studies across the region indicate that many male clients are married or have a long-term sexual partner.[15] In India, which alone accounts for almost half of the HIV burden in Asia, it is estimated that there are as many as 8.5 million male clients of female sex workers between 15 and 49 years and that, of these men, 55 percent are married.[16] Across parts of Asia, these male clients are intermediaries for HIV transmission from sex workers to women considered to be at low risk of infection. Yet, despite the significant role of male clients in the transmission of HIV to their intimate (usually female) partners, the factors that contribute to their sexual risk behaviour and their choices about contraception (especially with their regular/long-term partners or spouses) remain poorly documented and understood.

[14] Higgins et al. (2010), "Rethinking Gender, Heterosexual Men, and Women's Vulnerability to HIV/AIDS," *American Journal of Public Health* 100, 2010: 435–445.

[15] McLaughlin, M., et al. (2013), "Sexually Transmitted Infections among Heterosexual Male Clients of Female Sex Workers in China: A Systematic Review and Meta-Analysis, PLoS ONE, 8.8, 2013, article e71394; Xia Jin et al. (2010), "HIV prevalence and risk behaviours among male clients of female sex workers in Yunnan, China, *Journal of Acquired Immune Deficiency Syndrome* 53.1, Jan 2010: 131–135; Gaffey, M. F., S. Venkatesh, and N. Dhingraetal. (2011), "Male use of female sex work in India: A nationally representative behavioural survey, PLoS ONE 6.7, article e22704; Nguyen et al (2009). "Clients of Female Sex Workers as a Bridging Populations in Viet Nam," AIDS and Behavior 12.5, Oct 2009: 881–891.

[16] Gaffey, et al., *Male use of female sex work in India*.

Behavioural determinants of HIV vulnerability for this population include engagement in commercial sex, concurrent multiple sex partners, low condom use during last sexual act, and poor health-seeking.[17] Among the small-scale studies that address men's sexual decision-making, the role of social determinants – especially peer groups – in influencing the sexual behaviours of male clients appears to be critical.[18]

Although little attention has been paid to the **structural determinants** of their HIV risk and vulnerability, there is some evidence that expectations about gender roles and masculinity also play an important part. Research findings in Cambodia, for instance, indicate that the normalization of commercial sex as acceptable entertainment, pressure from peer groups to engage in outings that involve drinking and commercial sex, and disassociation from community and family norms are major factors in male sexual decision-making.[19] The findings also highlight the complex interplay between behavioural, social, and structural factors that lead men to engage in commercial and non-commercial sexual behaviours that can put them, as well as their intimate partners, at greater risk of HIV infection. For example, men may be reluctant to raise issues of trust and fidelity by introducing, or reintroducing, condoms into an intimate partner relationship; and though commercial sex work per se is not a risk factor for HIV, condom use that varies between types of partners, unsafe sexual behaviours, and inconsistent condom use increases vulnerability to sexually transmitted infections (STIs), including HIV.

> We spoke in advance: 'After drinking, where will you go?' I asked. He said 'I will go to have sex.' I said. 'Hey! I'm not going to go!' He said, 'You have to go. I'm going, so you should go, too.' When he says it like that, we have to go; if we don't go, it means that we are against him. Thus, our friendship will be broken up. Therefore, to keep our friendship strong or to avoid an argument between us, we have to go to have sex.
>
> **34-YEAR-OLD MALE CLIENT OF SEX WORKER, CAMBODIA. CITED IN POPULATION SERVICES INTERNATIONAL/ FAMILY HEALTH INTERNATIONAL (2007).**

Men who inject drugs

The experience of countries such as Indonesia and Thailand show how the spread of HIV among people who inject drugs has been critical to the trajectory of HIV epidemics in parts of Asia.[20] Among men who inject drugs, HIV prevalence in this population exceeds 20 percent in Cambodia, Indonesia, Pakistan, and Thailand. While HIV transmission through unsterile injecting equipment is considerably higher than through unprotected sex, risky sexual practices by people who inject drugs, including low condom use, increase the potential for sexual transmission of HIV.[21] Since data shows that between 25 and 60 percent of men who inject drugs in the region are married or have a regular female partner, high prevalence of HIV among this population has important implications for intimate partner transmission.[22] Despite this, coverage of prevention programmes for people who inject drugs and their sexual partners remains low, exacerbated by a lack of data on the relationship between drug use and unsafe sexual behaviour, especially with intimate partners.[23]

Overall, there is limited information available on the association between the risk behaviours of men who inject drugs in Asia (i.e. unsafe injecting drug use and unprotected sex with casual paid/unpaid female partners) and inconsistent condom use with regular partners (usually defined as wives or girlfriends).[24]

[17] Wee, S. et al., "Determinants of inconsistent condom use with female sex workers among men attending the STD clinic in Singapore," Sexually Transmitted Infections 80: 310–314; Population Services International (PSI)/Family Health International(FHI) (2007), *Let's Go for a Walk: Sexual Decision-making among Clients of Female Entertainment Workers in Phnom Penh, Cambodia* (Phnom Penh): 4–5; Rastogi, S. (2014), "Prevalence and Predictors of Self-Reported Consistent Condom Use among Male Clients of Female Sex Workers in Tamil Nadu, India," *Journal of Sexually Transmitted Diseases*, e952085.

[18] VanLandingham, M., J. Knodel, C. Saengtienchai, and A. Pramualratana, A. (1998), "In the company of friends: Peer influence on Thai male extramarital sex," *Social Science and Medicine* 47.12: 1,993–2,011; PSI/FHI, *Let's Go for a Walk;* Rastogi, "Prevalence and Predictors."

[19] PSI/FHI, *Let's Go for a Walk*.

[20] UNODC, at https://www.unodc.org/southeastasiaandpacific/en/topics/hiv-and-aids/overview.html.

[21] Mishra et al., "HIV risk behaviours of male injecting drug users and associated non-condom use with regular female sexual partners in north-east India," Harm Reduction Journal 11.5 (2014), at http://www.harmreductionjounral.com/content/11/1/5.

[22] UNAIDS, *HIV Transmission in Intimate Partner Relationships*.

[23] UNODC, at https://www.unodc.org/southeastasiaandpacific/en/topics/hiv-and-aids/overview.html.

[24] Mishra et al., "HIV risk behaviours."

This is despite evidence that in some high HIV-prevalence settings in Asia, men who inject drugs are more likely to transmit HIV to their spouses and regular sex partners than to sex workers.[25] Recent small-scale studies suggest a significant association between risky sexual practices with casual partners and non-condom use with their regular sexual partners.[26] Additionally, there is emerging evidence that men who inject drugs who share needles are more likely to engage in unprotected sex with their regular female partners.[27] Alongside these **behavioural determinants** of HIV risk, the high level of social stigma attached to drug use undermines service delivery to men who inject drugs and prevents them from seeking and accessing health care, including STI and HIV services. These **social factors** can be compounded by **structural factors;** for example, criminalization of drug use and harmful gender norms, which can influence both men's injecting behaviour and sexual risk behaviours. Research conducted with men who inject drugs in Afghanistan, China, India and Indonesia report how needle sharing often occurs during activities with other men, reinforcing masculine norms and making unsafe injecting a more accepted behaviour.[28] Conceptions of masculinity that emphasize men's sexual desire and sensation-seeking may also influence risky sexual practices (including engagement in commercial sex), although research in this area remains limited.[29]

Men who have sex with men and male sex workers

Research from the region shows that a substantial proportion of **men who have sex with men** (MSM) and **male sex workers** have high numbers of male and female partners of all types – regular, casual, commercial (paid), and paying.[30] In many countries, MSM report both intimate (i.e. regular) female sexual partners and commercial female partners. The percentage of MSM who report having had sex with females varies. In parts of India it ranged from 12.6 to 69.6 percent (over a period of six months), in Thailand it was 22.3 percent (over six months), and in Timor-Leste it was 93.6 percent (over twelve months).[31] Overall, information on the proportion of MSM married to women is limited, but it is clear that same-sex behaviour does not preclude sex with women or traditional marriage in many parts of Asia.[32] Where data is available, it suggests that marriage could be seen as the norm for many MSM. For example, between 10 and 55.6 percent of MSM in India were married; and in 2009 data from Kathmandu, Nepal, 37.8 percent of MSM (non-male sex workers) and 16.2 percent of male sex workers were married to women.[33] These figures have key implications for preventing intimate partner transmission of HIV, including transmission to the female spouses and intimate partners considered to be at low risk of infection. It also underscores why information on the determinants of HIV risk and vulnerability among MSM is critical to developing prevention strategies for intimate partner transmission of HIV.

[25] For example, a modeling exercise found that men who inject drugs were more likely to transmit HIV to their spouses and regular sex partners than to sex workers in any city in Pakistan. Source: *HIV risk in spouses of IDUs and sex workers in Pakistan*, presented at the 17th meeting of the International Society for Sexually Transmitted Diseases Research, Seattle, Washington, 30 July–1 August 2007.

[26] Mishra et al., "HIV risk behaviours."

[27] Ibid.

[28] Choi, S. Y. P., Y. W. Cheung, and K. Chen, "Gender and HIV Risk Behavior Among Intravenous Drug Users in Sichuan Province, China," *Social Science and Medicine* 62:1,672–678; Kermode et al. (2009), "Killing Time with Enjoyment: A Qualitative Study of Initiation into Injecting Drug Use in North-East India," *Substance Use and Misuse* 44.8; UNODC (2014), *Impacts of Drug Use on Users and Their Families in Afghanistan* (Kabul); Nasir, S. (2009), *Culture, Local Construct of Masculinity and HIV-Risk Practices among Young Male IDU in a Slum Area in Makassar, Indonesia*. Aids 2031: Mobilizing Social Capital in a World with AIDS, 30 March–1 April 2009, Salzburg, Austria.

[29] Prakash, B., "Reasons for Sexual Promiscuity In Chemically Dependent Respondents and their Awareness and Acceptance of Condom Use," *Indian Journal of Preventive and Social Medicine* 24: 1–2.

[30] Koh et al., "Sexual practices and HIV prevalence amongst men who have sex with men at a community-based voluntary counseling and testing centre in Malaysia," *ISRN Infectious Diseases*, (2013) article ID 247545; Narayanan et al. (2013), "An exploration of elevated HIV and STI risk among male sex workers from India," *BMC Public Health* 13, 2013:1059; WHO Regional Office for South-East Asia (SEARO) (2010), *HIV/AIDS among Men Who Have Sex with Men and Transgender Populations South-East Asia: The Current Situation and National Responses* (New Delhi); Thomas et al., "HIV in Indian MSM: Reasons for a concentrated epidemic and strategies for prevention," *Indian Journal of Medical Research* 134; Treat Asia Special Report, *MSM and HIV/AIDS Risk in Asia. What is fueling the epidemic among MSM and how can it be stopped?* (2006).

[31] SEARO, *HIV/AIDS among Men Who Have Sex with Men*.

[32] Ibid., Thomas et al.

[33] SEARO, *HIV/AIDS among Men Who Have Sex with Men*.

Behavioural factors that increase HIV risk among this population group include concurrent multiple sex partners, low condom use during last sexual act, drug use, engagement in commercial sex, poor health-seeking, and internalized stigma (self-stigma).[34] In-country research conducted with young MSM in East Asia, South Asia and South-East Asia reported that self-stigma makes it particularly difficult for these men to have beneficial intimate partner relationships and to take care of their health.[35] Many of these young MSM indicated that they would like to be in fulfilling romantic relationships and expressed their desire to experience love and affection from an intimate partner. Yet self-stigma and low self-esteem was found to contribute to harmful relationship dynamics. For example, some young MSM in the study reported entering into unequal relationships with older people. In these relationships, the young people reported the presence of a power dynamic, whereby the older person had more control over the relationship, often dictating his sexual preferences, including the avoidance of condoms and sometimes expressing a role preference for insertive anal sex. Unprotected receptive anal sex is a high-risk behaviour for HIV, but some young MSM said they did not have the confidence or negotiation skills to discuss this risk with an older partner. Young MSM who reported feeling ashamed of their sexuality also appeared less likely to have healthy intimate partner relationships.[36]

> The MSM teenagers who use drugs always shout and curse at the other MSM and transgender persons. For the first time they invited me to go to the river bank, and after they have sex with me they hit me because I refused to take drugs with them… I decided to use drugs with them after that.
>
> **YOUNG MSM, CAMBODIA. CITED IN YOUTH VOICES COUNT (2014).**

Evidence shows that these behavioural factors do not exist in isolation but are affected by the **social environment** in which MSM live. In addition to unequal power within intimate partner relationships, this includes the high levels of stigma, discrimination and violence that MSM face within their communities, from health care institutions and law enforcement agencies as well as reduced access to and demand for STI/HIV information and services resulting from social exclusion.[37] **Structural** factors such as lack of economic independence, including low access to employment and opportunities, have also been shown to increase HIV risk and vulnerability.[38] In Asia, traditional gender roles and norms mean MSM often experience strong pressure from their families to marry and have children, making it harder to adopt protective behaviours – including consistent condom use with spouses/intimate female partners. HIV prevention intervention efforts among MSM that focus on behavioural factors, including efforts to prevent HIV transmission within their intimate partner relationships, have been hampered by a lack of understanding of this interplay between individual sexual behaviours and social and structural factors.

Common determinants of HIV risk and vulnerability among male key populations in Asia

Among the limited research conducted, it is evident that behavioural, social, and structural factors interact in various ways to increase HIV vulnerability among men in Asia. These factors affect how adult and adolescent male key populations behave as individuals and how they behave in their sexual relationships with others, including with intimate partners. This explains why prevention efforts that seek to address only one type of determinant (e.g. low condom use) are less likely to work. Though the individual experience of male clients of sex workers, men who inject drugs, men who have sex with men and male sex workers may be different, research points to common determinants of risk behaviours that place them and their intimate sexual partners at risk of infection. For example, inconsistent condom use with concurrent sexual partners, engagement in commercial sex, low condom use with intimate partners (and associated issues around trust

[34] Thomas et al., "HIV in Indian MSM"; García, M. C., S. B. Meyer, and P. Ward (2012), "Elevated HIV prevalence and risk behaviours among men who have sex with men (MSM) in Vietnam: A systematic review," *BMJ Open* 2:e001511.doi:10.1136; Treat Asia Special Report, *MSM and HIV/AIDS Risk in Asia*.

[35] Youth Voices Count (2014), *The Hidden Dimension: Experience of self-stigma among young men who have sex with men and young transgender women and the linkages to HIV in Asia and the Pacific* (Bangkok). This in-country research was conducted in Cambodia, China, Indonesia, Lao PDR, Mongolia, Nepal, Pakistan, Philippines, Sri Lanka, and Viet Nam.

[36] Ibid.

[37] Thomas, "HIV in Indian MSM."; Treat Asia Special Report, *MSM and HIV/AIDS Risk in Asia;* SEARO, *HIV/AIDS among Men Who Have Sex with Men;* Ngo et al. (2009), "Male homosexual identities, relationships, and practices among young men who have sex with men in Vietnam: Implications for HIV prevention, *AIDS Education and Prevention* 21.3, June 2009:251–265; Chemnasiri et al. (2010), "Inconsistent condom use among young men who have sex with men, male sex workers, and transgenders in Thailand, *AIDS Education and Prevention* 22.2: 100–109; Bengtsson et al. (2013), "Sexual relationships among men who have sex with men in Hanoi, Vietnam: A qualitative interview study, *BMC Public Health* 13:108.

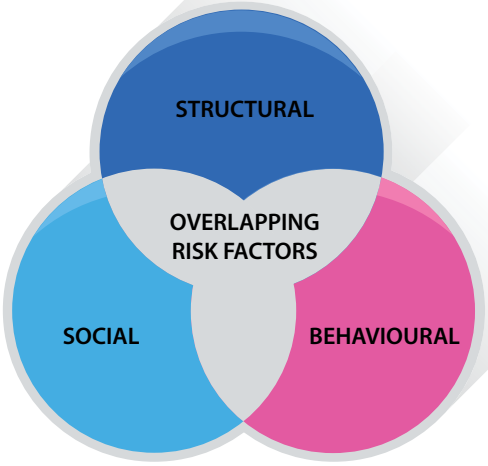
[38] Ibid.

and fidelity when introducing condoms into these relationships), and poor health-seeking behaviour all appear to be common risk behaviours across male key populations in Asia. Evidence also points to the central importance of the social (peer networks, stigma, discrimination, violence) and political (laws, policies) environment in shaping HIV risk and vulnerability among these populations. There is also growing evidence to suggest HIV risk among male key populations across the region is heightened as a result of structural factors, including harmful gender norms and conceptions of masculinity.

Data across the region shows that a significant number of male clients of sex workers, men who inject drugs, men who have sex with men, and male sex workers not only have female sex partners but a significant number have female spouses and regular female partners. Yet HIV prevention efforts to reduce transmission within intimate relationships are being hindered as many Asian countries lack information on the determinants of HIV vulnerability and transmission among adult and adolescent male key populations. Improving our understanding of the different determinants of HIV risk and vulnerability among these populations – and the way these interact – could maximize the effectiveness of prevention programmes in the region, including efforts to prevent intimate partner transmission. It may also increase acceptability of these programmes by male key populations.

Men from key populations: Common determinants of HIV risk and vulnerability in intimate partner relationships

- Harmful gender roles/norms and conceptions of masculinity
- Laws and policies that criminalize behaviours that affect men from key populations and those living with HIV
- Legal and policy barriers that constrain access to STI, HIV and SRHR information and services
- Limited economic opportunities



- High levels of social stigma and exclusion
- Peer pressure
- Unequal power within intimate partner relationships
- Reduced access and demand for STI, HIV and SRHR information and services because of the social environment
- Violence, including from law enforcement agents

- Self-stigma
- Engagement in commercial sex*
- Concurrent multiple sex partners
- Poor health seeking
- Unsafe injecting drug use
- Unprotected sex with casual partners
- Low or inconsistent condom use with intimate partners and associated issues around trust and fidelity when introducing condoms into these relationships

* Though commercial sex work per se is not a risk factor for HIV, condom use that varies between types of partners, unsafe sexual behaviours, and inconsistent condom use increases vulnerability to STIs, including HIV.

2.3 Female partners who engage in high-risk behaviours

Female key populations in Asia are at heightened risk of HIV infection because of both their own behaviours and that of their male sexual partners, including their intimate partners. Although there is some evidence of HIV transmission from women to their intimate male partners, male risk behaviours continue to drive HIV transmission in the region, including intimate partner transmission. Research shows that women from key populations in Asia have a range of sexual partners, including spouses and intimate partners as well as other partners, both casual and commercial. In these interactions, a variety of factors contribute to their high-risk behaviour and choices about contraception, including how they negotiate safer sex. The following section focuses on factors that affect HIV risk and vulnerability among female sex workers, women who use drugs, and transgender women, with a focus on how this affects their ability to negotiate safer sex with their sexual partners, including intimate partners.

Female sex workers

Although there has been progress in reducing new HIV infections among female sex workers across the region, the burden of HIV infection continues to be disproportionately high among this community, who are 29 times more likely to be infected by HIV than the rest of the adult female population in Asia.[39] Research studies and IBBS data show that a significant number of these sex workers are married or have regular non-paying sexual partners, and this has implications for intimate partner transmission of HIV. Data from the 2011 IBBS in Nepal and Pakistan reported that more than one-half of female sex workers were currently married (52.4 and 57.0 percent, respectively); 70.2 percent in Bangalore, India, reported being in a 'stable' relationship; and a smaller-scale study among 498 female sex workers in Manila, Philippines, reported that 28 percent were married or had a live-in boyfriend.[40] Yet it is difficult to talk about sex workers in Asia as a single 'group' because those involved in sex work come from a diverse range of backgrounds and cultures. Consequently, the factors that shape HIV risk among female sex workers can vary depending on their age, the country they live in, whether they work in a brothel or are street-based, their access to condoms, and the frequency of unprotected sex acts they have with each partner.[41] Research also shows that female sex workers in the region experience intimate relationships in a range of ways, both positively and negatively, and in ways that can heighten or reduce their risk of contracting HIV.[42]

Despite the diversity among the female sex worker population in Asia, there are common determinants of HIV risk and vulnerability that affect their choices about contraception and how they negotiate safer sex, including with their intimate partners. The **behavioural determinants** of HIV risk among this population include: engagement in commercial sex; concurrent multiple sex partners; low condom use during last sexual act; drug use; poor health-seeking behaviour; and low levels of knowledge about STI and HIV transmission and prevention. Social stigmatization of sex work and reduced access to information and services resulting from social exclusion, unequal power within intimate partner relationships, and violence (including intimate partner violence) have all been identified as important **social determinants** of HIV risk and vulnerability among female sex workers. Of these, research from the region shows that violence has a direct and indirect bearing on sex workers' ability to protect themselves from HIV, prevent HIV transmission to their sexual partners (including intimate partners), and to access HIV testing, treatment and support. A growing body of evidence shows that female sex workers across Asia are subjected to high levels of violence from clients,

[39] UNAIDS, *HIV in Asia and the Pacific: UNAIDS Report 2013* (Bangkok).

[40] NCASC and ASHA Project 2011, *Integrated Biological and Behavioral Surveillance (IBBS) Survey among Female Sex Workers in Kathmandu Valley, Nepal, Round IV–2011* (Kathmandu); Mishra et al, "Sexual behaviour, structural vulnerabilities and HIV prevalence among female sex workers in Pakistan," *Sexually Transmitted Infections*. (published online, 14 February 2013); Jayaraman et al., "Demographic changes and trends in risk behaviours, HIV and other sexually transmitted infections among female sex workers in Bangalore, India involved in a focused HIV preventive intervention," *Sexually Transmitted Infections* 89.8 (Dec 2013): 635–41; Urada et al., "Condom Negotiations among Female Sex Workers in the Philippines: Environmental Influences," *PLoS ONE* 7.3 (2012):e33282.

[41] AVERT, "Sex Workers and HIV/AIDS," at http://www.avert.org/sex-workers-and-hivaids.htm.

[42] Studies have demonstrated some potential benefits as well as harms of sex workers' intimate partner relationships. A study of female sex workers in the border provinces of Viet Nam found that having an intimate male partner was a protective factor for HIV. Other research from the region has focused on the constraints of such relationships, including the low level of condom use and high levels of physical violence between couples, as well as the risk of HIV transmission. Sources: Thuong, N. V. et al., "HIV in female sex workers in five border provinces of Vietnam," *Sexually Transmitted Infections* 81 (2005):477–479, cited in Benoit et al., Benefits and constraints of intimate partnerships for HIV positive sex workers in Kibera, Kenya," *International Journal for Equity in Health* 12.76 (2013); Panchanadeswaran et al., "Intimate Partner Violence is as important as client violence in increasing street-based female sex workers' vulnerability to HIV in India," *International Journal of Drug Policy* 19.2 (2008): 106–112.

police and pimps.[43] By comparison, few studies have examined violence by intimate or other non-paying partners and how this affects the sexual risk behaviours of sex workers and their choices about contraception.[44] This underscores the ongoing research gap in understanding the link between different types of violence experienced by sex workers in Asia (including intimate partner violence) and how this affects their ability to negotiate safer sex with their male sexual partners, including intimate partners.[45] This includes the role of **structural factors** in determining HIV risk among female sex workers, such as the legal status of sex work, economic inequities and entrenched gender inequalities. It appears from published data that the structural realities and vulnerabilities that shape the lives of female sex workers in Asia are just as important as individual-level factors.

Taken together, research from the region points to the complex manner in which intimate and transactional relations are bound with one another and the diversity in sex worker-intimate partner relationships.[46] Efforts to reduce intimate partner transmission of HIV in Asia need to take this into account. Focusing only on behavioural factors, which assumes that a female sex worker has control over her environment and is the main person responsible for using contraception and negotiating safer sex (including with her intimate partner) ignores the critical role that social and structural factors have in influencing sexual risk behaviours among this population.

Women who inject drugs

Although few countries in the region systematically collect gender-disaggregated data related to injecting drug use, estimates indicate that women are a sizeable minority of people who inject drugs. In China, which is estimated to represent the majority of people who inject drugs in Asia, females account for nearly 20 percent of all drug users, increasing to 40 percent in some provinces.[47] Reports from India suggest a gradual increase in the number of women who inject drugs.[48] In other parts of the region, the estimated number of women as a percentage of all people who inject drugs are 11 percent in Indonesia, 10 percent in Cambodia and Malaysia, and 8 percent in Viet Nam.[49]

Adult and adolescent females who inject drugs are not only vulnerable to HIV infection because of unsafe drug injecting practices, but they are also often involved in unsafe sexual practices, including with their intimate partners, which further increases their vulnerability to HIV transmission. Despite limited research, existing evidence indicates that the majority of women who inject drugs have regular male sex partners. Compared to their male counterparts, women who inject drugs are also more likely than their male counterparts to have a sexual partner who injects drugs.[50] Research suggests that around two-thirds of women who inject drugs in the region have a male intimate partner, often a man who also injects drugs.[51]

[43] Bhattacharjya, M., Fulu, E. and Murthy, L. with Seshu, M.S., Cabassi, J. and Vallejo- Mestres, M. (2015). The Right(s) *Evidence – Sex Work, Violence and HIV in Asia: A Multi- Country Qualitative Study* (Bangkok: UNFPA, UNDP and APNSW (CASAM).

[44] In a study of 1,022 female sex workers in China, 58 percent of respondents had experienced violence from their intimate partners (as compared to 10–38 percent of women in the general population) and 45 percent suffered violence from clients. While the research pointed to the direct link between intimate partner violence, poor mental health outcomes, and substance abuse among female sex workers, the relationship between intimate partner violence and the increased risk of HIV among female sex workers was left largely unexplored. Source: Hong et al. (2013), "Partner Violence and Psychosocial Distress among Female Sex Workers in China," PloS ONE 8.4.

[45] A notable exception is Bhattacharjya et al. (2015), "*The Right(s) Evidence – Sex Work, Violence and HIV in Asia*".

[46] Ibid.

[47] Cited in Choi et al., "Gender and HIV risk behavior."

[48] UNODC & National AIDS Control Organisation, India (2012), *Female Injecting Drug Users and Female Sex Partners of Men who Inject Drugs: Assessing Care Needs and Developing Responsive Services* (New Delhi).

[49] Pinkham et al. (2012), "Developing Effective Health Interventions for Women Who Inject Drugs: Key Areas and Recommendations for Program Development and Policy," *Advances in Preventive Medicine:* article ID 269123.

[50] Stoicescu, C., ed. (2012), *The Global State of Harm Reduction 2012: Towards an Integrated Response* (London: Harm Reduction International).

[51] A 2010 study conducted among 1,391 female drug users in Pakistan reported that nearly 60 percent were currently married. A cross-sectional study conducted in 2013 of female drug users in Nepal found that two-thirds of the participants were married and/or cohabiting with their male intimate partners. A similar finding was reported in a 2009 small-scale study with women who injected drugs in Indonesia, which noted that three-quarters were living with their spouse or boyfriend, mostly a man who also injected drugs. Sources: UNODC (2010), *Female Drug Use in Pakistan: Mapping Estimates, Ethnographic Results and Behavioural Assessment* (Islamabad); Ghimire et al. (2013), "Vulnerability to HIV infection among female drug users in Kathmandu Valley, Nepal: A cross-sectional study," BMC Public Health 13: 1,238; Saktiawati et al. (2013), "I just trust him: The notion of consideration as a barrier to condom use amongst women who inject drugs in Central Java," *World Journal of AIDS* 3: 298–304.

Small-scale studies from Bangladesh, China, Indonesia and Thailand also show that HIV risk among women who inject drugs frequently occurs within the context of an intimate relationship involving regular male sex partners.[52] This suggests that for these women, the expectations and experiences of their intimate partner relationships may place them at greater risk of acquisition or transmission of HIV. Specifically, intimate partner relationships can influence the sexual risk behaviours of women who inject drugs at the individual level. For example, women interviewed in China, Indonesia and Thailand described their intimate partnerships with male drug users as characterized by dependence intertwined with reliance, sharing and support.[53]

In Indonesia, a study among women who inject drugs found that they tended to depend upon their intimate male partners to obtain drugs, injecting equipment or condoms.[54] This type of reliance, coupled with the economic pressures of supporting drug dependency, can also make women who inject drugs more likely to engage in sex work. There is a major nexus between injecting drug use and sex work: it is estimated that approximately half of women who inject drugs in Asia sell sex.[55] Engagement in sex work remains an important **behavioural determinant** of HIV risk for women who inject drugs. Studies from the region indicate that many women who inject drugs and also engage in sex work are married or have an intimate partner.[56] These women often sell sex to provide for their partner and/or family as part of the gendered division of labour. Many report having concurrent commercial and non-commercial sex partners, and a substantial proportion report not using condoms with their regular male sex partners.[57] Unsurprisingly, research shows that women who inject drugs and engage in sex work have higher HIV prevalence than their peers who do not sell sex.[58] This overlap between women's sexual and drug-using networks puts women who inject drugs and their intimate sexual partners at heightened risk of HIV infection.

Partner violence also contributes to risk behaviour and choices about contraception, including how women who inject drugs negotiate safer sex with intimate partners. Interviews with women who inject drugs in Bangkok disclosed they frequently experienced intimate partner violence. This is consistent with the findings of other studies that estimate higher prevalence of intimate partner violence among women who use drugs as compared to women who do not use drugs.[59] Intimate partner violence together with other **social factors**, such as the stigma attached to women's injecting drug use, can make these women less capable of insisting on safe sex and injection behaviours, or less likely to seek out sexual and reproductive health, HIV and harm reduction services. The double stigmatization they face (i.e. not only as drug users but because society views these women as deviating from traditional gender roles as wives, mothers, daughters or nurturers of families) also highlights how gender and structural inequality can influence the unsafe sexual practices of women who inject drugs, including with their intimate partners. This is compounded by other **structural factors**, such as punitive policy and legal environments, which often prevent women who inject drugs from accessing essential HIV prevention services, and which exacerbate the vulnerabilities and risks that they face.

> How could I tell anyone that my boyfriend beat me badly? If I go to the police station to report the domestic violence, I would be charged with drug use. Probably I could be sent to prison, and who would take care of my kids? Surely my husband could not take care of them. That would lead them to a miserable life, just like mine.
>
> **WOMAN WHO INJECTS DRUGS, BANGKOK, THAILAND. CITED IN HARITAVORN (2014).**

[52] Azim et al. (2006), "Vulnerability to HIV infection among sex worker and non-sex worker female injecting drug users in Dhaka, Bangladesh: Evidence from the baseline survey of a cohort study," *Harm Reduction Journal* 3:33; Choi et al., "Gender and HIV risk behavior"; Lau et al. (2009), "Comparing prevalence of HIV-related behaviours among female injecting drug users (IDU) whose regular sexual partner was or was not IDU in Sichuan and Yunnan Provinces, China," *AIDS Care* 21.7, Jul 2009: 909–917; Saktiawati et al., "I just trust him"; Haritavorn, N. (2014), "Surviving in two worlds: Social and structural violence of Thai female injecting drug users," *International Journal of Drug Policy* 25: 116–123.

[53] Ibid.

[54] Saktiawati et al., "I just trust him."

[55] Cited in WHO Regional Office for South-East Asia (2009), *Management of Common Health Problems of Drug Users* (India).

[56] Roberts, A., B. Mathers, and L. Degenhardt on Behalf of the Reference Group to the United Nations on HIV and Injecting Drug Use (2010), *Women Who Inject Drugs: A Review of Their Risks, Experiences and Needs* (National Drug and Alcohol Research Centre (Sydney, Australia: University of New South Wales).

[57] Azim et al., "Vulnerability to HIV infection."

[58] Cited in Pinkham et al., "Developing Effective Health Interventions for Women Who Inject Drugs."

[59] Haritavorn, "Surviving in two worlds"; Pinkham et al., "Developing Effective Health Interventions for Women Who Inject Drugs."

Transgender women

Although regional research and data on HIV risk and prevalence among transgender people is limited, published data indicates high HIV prevalence among transgender women in many cities, provinces, and states including 30.8 percent in Jakarta, Indonesia, 18.8 percent in Maharashtra, India, and over 10 percent in Bangkok, Chiang Mai and Phuket in Thailand.[60] Global evidence indicates that epidemics in transgender women happen in the wider context of high burden epidemics among men who have sex with males (irrespective of their sexual identity or partnerships with females), some of whom might also partner with transgender women.[61] In Asia, transgender women have been consistently identified as engaging in receptive anal sex with men, putting them at substantially greater risk of HIV than their partners.[62]

However, relatively little remains known about these women and their sexual relationships, including their negotiation of safer sex with intimate/regular, casual and commercial partners. To date, transgender populations in the region have predominantly been studied in the context of sex work, and this may contribute to generalizations about the sexual behaviours of transgender women while masking the complexity of how they negotiate HIV risk with intimate/regular partners. This has led to calls for HIV prevention interventions for transgender women to address high-risk behaviour in the context of their intimate partner relationships as well as sex with concurrent partners outside the relationship.[63] The few studies that do exist have been small-scale and locally based, making findings difficult to generalize to a larger population. Nonetheless, published data appears to show that many transgender women who are sexually active become involved in multiple relationships and engage in high-risk sexual behaviours.[64]

Important **behavioural determinants** of HIV vulnerability for this population include self-stigma, low condom use during last sexual act, engagement in commercial sex, concurrent multiple sex partners, and poor health-seeking. In the context of their intimate relationships, transgender women in the region who report multiple relationships also report lower condom use with regular/intimate male partners compared with casual or commercial partners.[65] Reasons for this are not well documented, but anecdotal reports suggest that self-stigma, age and gender-based power relationships can all make it more likely that a transgender woman feels unable to negotiate condom use with her partner.[66] The perception that condom use is associated with the absence of trust and intimacy, mediated by conformity to gender role norms that emphasize male sexual pleasure, may be another explanatory factor. Evidence suggests that some transgender women who want to affirm their gender through sex or who fear rejection from their intimate male partners are more likely to agree to unprotected sex.[67]

> I don't mind if my husband beats me up. It only shows how manly and powerful he is.
>
> **TRANSGENDER WOMAN, INDIA. CITED IN NAZ FOUNDATION INTERNATIONAL (2010).**

[60] UNAIDS, *HIV in Asia and the Pacific*.

[61] Baral et al. (2013), "Worldwide burden of HIV in transgender women: A systematic review and met-analysis," *The Lancet Infectious Diseases* 13: 214–222.

[62] For comparison, the risk of transmission for unprotected receptive anal intercourse (around 1.4 percent per act) is around 18-times higher than for vaginal intercourse. Cited in UNDP & Asia Pacific Transgender Network (2012), *Lost in Transition: Transgender Persons, Human Rights and HIV Vulnerability in Asia and the Pacific* (Bangkok).

[63] Operario, D. (2011), "Unprotected Sexual Behaviour and HIV Risk in the Context of Primary Partnerships for Transgender Women," *AIDS and Behavior* 15.3, Apr 2011: 674–682.

[64] UNDP, APTN, *Lost in Transition; UNDP (2010), Hijras/Transgender Women in India: HIV, human rights and social exclusion* (New Delhi).

[65] In a study among *lao kathoy* (male-to-female transgender persons), 57.5 percent reported condom use with casual partners but only 23.5 percent reported condom use with intimate/regular partners; another study from Thailand reported consistent condom use during anal intercourse with casual partners, but only 39 percent consistent condom use with regular partners. Among transgender sex workers in a Thai study, 86 percent reported engaging in unprotected anal sex with regular partners and 27 percent reported unprotected anal sex with commercial partners. Sources: Longfield et al. (2011), "Increasing safer sexual behaviour among Lao kathoy through an integrated social marketing approach," *BMC Public Health* 11.872; Guadamuz et al. (2011), "HIV prevalence, risk behavior, hormone use and surgical history among transgender persons in Thailand," *AIDS and Behavior* 15: 650–658; Nemoto et al. (2012), "HIV-related risk behaviours among kathoey (male-to-female transgender) sex workers in Bangkok, Thailand," *AIDS Care* 24: 210–219.

[66] APTN and Asia Pacific Coalition on Male Sexual Health (APCOM) (2013), *Policy Brief: Overlooked, Ignored, Forgotten: HIV and Basic Rights of Transgender People in Asia and the Pacific (Bangkok); UNDP, APTN, Lost in Transition*.

[67] Youth Voices Count, *The Hidden Dimension; AVERT, Transgender People and HIV/AIDS*, at http://www.avert.org/transgender-hiv.htm.

BOX 2 FEMALE KEY POPULATIONS, VIOLENCE AND NEGOTIATING HIV RISK IN INTIMATE PARTNER RELATIONSHIPS

Global evidence shows that the causal pathways linking intimate partner violence and HIV are complex and multilayered. This means there are often direct and indirect links between the factors that contribute to sexual risk behaviour and choices about contraception. For example, violence within an intimate relationship can reduce a partner's ability to influence the timing and circumstances of sex, resulting in more unwanted sex and less condom use, including situations where the victim of violence is coerced or pressured not to use condoms. Studies have linked male-perpetrated intimate partner violence with sexual risk behaviours that place both themselves and their intimate female partners at increased risk of HIV infection.

Studies from the region indicate that women from key populations experience higher levels of intimate partner violence compared to women in the general population:

- In a study of 123 sex workers in Indonesia, Myanmar, Nepal and Sri Lanka, female participants reported more frequent and severe incidents of intimate partner violence than the male and transgender participants. In most cases, the violence was described as severe, routine and chronic. Of the female participants, almost half of those in Indonesia, one third in Myanmar and several in Nepal and Sri Lanka reported being raped by their intimate partner.
- In a study of 1,022 female sex workers in China, 58 percent of respondents had experienced violence from their intimate partners (as compared to 10–38 percent of women in the general population) and 45 percent suffered violence from clients.
- A survey conducted with 1,043 female entertainment workers across seven provinces in Cambodia found that they were more likely to experience violence from a client (55 percent) when negotiating condom use, although a significant proportion also reported abuse from husbands and regular partners (26 and 31 percent, respectively) when suggesting they use a condom.
- Sex workers in India have acknowledged that acts of violence are probably underreported, particularly violent incidents involving intimate/regular partners.
- A study among women who inject drugs in Bangkok found that violence was an integral part of these women's lives; the majority of respondents reported that they regularly experience violence at the hands of their intimate male partners.

Past exposure to gender-based violence and controlling behaviour from an intimate partner is consistently associated with subsequent high-risk sexual behaviour, including multiple and concurrent sexual partnerships, increased number of overall partners, lower levels of condom use and increased participation in transactional sex as well as commercial sex work. In Asia, there is a growing body of evidence that adult and adolescent female key populations experience intimate partner violence, and that the threat and/or presence of violence affects their sexual decision-making and contraceptive choices.

All UN Member States in Asia have committed to "eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV" by 2015 (2011 UN Political Declaration on HIV and AIDS). Violence, including intimate partner violence, needs to be viewed as a critical determinant of HIV risk and vulnerability among women from key populations in Asian countries and addressed in both National Strategic Plans on HIV/AIDS (NSPs) as well as in national gender equality frameworks (e.g. National Action Plans to eliminate violence against women). While more and more countries in the region are reporting on the links between gender-based violence and HIV vulnerability, NSPs do not always include clear strategies to address violence against female key populations. This is often mirrored by a lack of resources in sectoral budgets (such as health, education and justice) and Global Fund grant allocations for issues specific to gender-based violence, especially violence against key populations.

Sources: Higgins et al. (2010), "Rethinking Gender, Heterosexual Men, and Women's Vulnerability to HIV/AIDS," *American Journal of Public Health* 100: 435–445; Dunkle, K. L. and M. R. Decker (2013), "Gender-based violence and HIV: Reviewing the evidence for links and causal pathways in the general population and high-risk groups," *American Journal of Reproductive Immunology* 69 (Suppl. 1, 2013): 20–26; Bhattacharjya, M., Fulu, E. and Murthy, L. with Seshu, M.S., Cabassi, J. and Vallejo- Mestres, M. (2015). *The Right(s) Evidence – Sex Work, Violence and HIV in Asia: A Multi- Country Qualitative Study* (Bangkok: UNFPA, UNDP and APNSW (CASAM); Hong et al., "Partner Violence and Psychosocial Distress among Female Sex Workers in China," *PloS ONE* 8.4: e62290. doi:10.1371; FHI 360/PRASIT Project (2010). *SMARTgirl Program Review: Providing HIV/AIDS Prevention and Care for Entertainment Workers. Reporting period October 2008–June 2010* (Phnom Penh); Reza-Paul et al. (2012), "Sex worker-led structural interventions in India: A case study on addressing violence in HIV prevention through the *Ashodaya Samithi* collective in Mysore," *Indian Journal of Medical Research* 135.1, Jan 2012: 98–106; Haritavorn, N. (2014), "Surviving in two worlds: Social and structural violence of Thai female injecting drug users," *International Journal of Drug Policy* 25: 116–123.

High levels of marginalization, violence, stigma, and discrimination characterize the complex social and economic context within which transgender women have to find a way to survive. For example, a significant proportion of transgender women in Asia engage in sex work attributable[68] in part to social stigma and employment discrimination, which limit opportunities for income generation and challenge basic survival needs.[69] Evidence shows that transgender sex workers are four times more likely to be living with HIV than female sex workers.[70] Here, the stigma of sex work – often enforced by the threat of violence – combines with gender inequalities to disempower transgender women sex workers and create barriers to negotiating safe sex practices.

Together, this underscores the interplay among **behavioural, social and structural factors** in influencing sexual decision-making and risk behaviours of transgender women with their intimate partners and any concurrent partners outside the relationship. Just as these factors combine to increase the risk of transgender women's sexual acquisition and transmission of HIV, it seems that many of their male sex partners are also likely to engage in high-risk sexual behaviours. This appears to be particularly the case with casual and commercial sex partners, although the absence of data on male intimate partners of transgender women makes it harder to understand each partner's HIV risk within the context of an intimate relationship.

Common determinants of HIV risk and vulnerability among female key populations in Asia

Just as men bring HIV into their partnerships from their previous relationships or by having concurrent partners, women can bring HIV into their intimate partner relationships for the same reasons. However, the reality remains that the HIV epidemic in Asia continues to be largely driven by male high-risk behaviours. Data across the region points to the fact that many female sex workers and women who inject drugs have male spouses or intimate partners.[71] A number of studies indicate that women who engage in high-risk behaviours may also have an intimate male sexual partner who engages in high-risk behaviours, whether it is unprotected sex with concurrent partners or injecting drug use with shared needles and syringes.

The intimate partner relationships of adult and adolescent female key populations in the low and concentrated HIV epidemics of Asian countries are complex and are often characterized by the overlap among injecting drug use, sex work, violence (including intimate partner violence) and structural inequalities, including gender inequalities and discrimination. Data from the region repeatedly points towards the importance of social stigmatization and marginalization and structural factors, especially traditional gender roles and norms and punitive laws and policies, in influencing how female key populations (including transgender women) behave in their sexual relationships with others, including their intimate male partners.

However, the overall lack of research on sexual decision-making and behaviour among these populations – including the reality that these women may intend to have children – makes it difficult to arrive at valid generalizations. This in turn, hinders HIV prevention efforts and can also perpetuate the view, unfairly, that female key populations are 'vectors of disease' and 'core transmitters', who have freedom in their sexual decision-making and are able to exert control over their reproductive choices, when available evidence suggests the opposite. Attempts to reduce intimate partner transmission of HIV in the region are likely to fail unless prevention efforts recognize that HIV risk among female key populations is heightened by the social environment in which they live and by the structural inequalities that affect how they negotiate this risk with their sexual partners.

[68] In one sample in Malaysia, 54 percent of transgender female participants reported a history of sex work. Another Indian estimate puts the proportion of transgender women involved in sex work at 80 percent. The World Bank estimates the number of female transgender sex workers in Pakistan to be 35,000 (nearly a fifth of all estimated sex workers nationwide). Cited in UNDP, APTN, *Lost in Transition*.

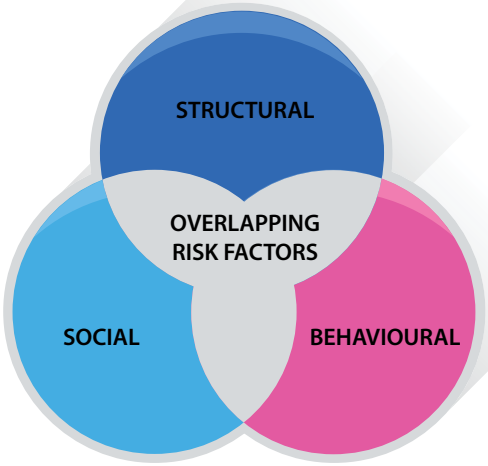
[69] Operario et al. (2009), "Sex Work and HIV Status Among Transgender Women: Systematic Review and Meta-Analysis," *Journal of Acquired Immune Deficiency Syndrome* 48: 97–103.

[70] Baral et al. "Worldwide burden of HIV in transgender women."

[71] Published data is not available on the estimated proportion of transgender women in the region who have a regular male intimate partner.

Women from key populations: Common determinants of HIV risk and vulnerability in intimate partner relationships

- Entrenched gender inequalities
- Harmful gender roles/norms and conceptions of femininity
- Laws and policies that criminalize behaviours that affect women from key populations and those living with HIV
- Legal and policy barriers that constrain access to STI, HIV and SRHR information and services
- Limited economic opportunities



- High levels of social stigma and exclusion
- Peer pressure
- Unequal power within intimate relationships
- Reduced access and demand for STI, HIV and SRHR information and services because of the social environment
- Violence, including from law enforcement agencies

- Self-stigma
- Engagement in commercial sex*
- Concurrent multiple sex partners
- Poor health seeking
- Unsafe injecting drug use
- Unprotected sex with casual partners
- Low or inconsistent condom use with intimate partners and associated issues around trust and fidelity when introducing condoms into these relationships

* Though commercial sex work per se is not a risk factor for HIV, condom use that varies between types of partners, unsafe sexual behaviours, and inconsistent condom use increases vulnerability to STIs, including HIV

2.4 HIV risk and vulnerability: Female intimate partners of men with high-risk behaviours

According to the Commission on AIDS in Asia (2008), most women living with HIV in the region will have been exposed to HIV during sex with an intimate male sexual partner who had been infected during commercial sex or when injecting drugs.[72] In Viet Nam, for example, confidential voluntary counselling and testing data from 2006 to 2010 showed that 54 percent of HIV-positive women reported that their only possible exposure to HIV was through an intimate male partner with high-risk behaviour.[73] Even taking into account possible response bias (i.e. female intimate partners under-reporting their own risk behaviours), there is widespread recognition of married women's elevated risk for HIV in parts of Asia. Surveys measuring condom use by men who know they are living with HIV[74], as well as mode of transmission analysis, seem to support the hypothesis that a majority of women in the region are becoming infected with HIV, not because of their own sexual behaviour, but because their intimate male partners have been engaged in high-risk behaviours.

In Asia, women who are at heightened risk of HIV include female intimate partners of men who are currently, or were formerly, part of a population at higher risk of HIV (e.g. male clients of sex workers, men who inject drugs, and men who have sex with men). For example, in Manipur, India, 45 percent of the wives of HIV-positive men who inject drugs who reported risky sexual behaviours were found to be HIV-positive.[75] In other parts of Asia, the wives of clients of sex workers have also been shown to be at an increased risk of infection, especially when the husband is a migrant worker returning from provinces or countries with a high HIV prevalence.[76] For instance in India and Nepal, studies have shown a higher HIV prevalence among wives of returnee migrant workers compared to women in the general population.[77] Female intimate partners in serodiscordant couples where the male partner is HIV-positive are also at greater risk of infection, especially if HIV status is not known or has not been disclosed within the relationship.[78]

HIV vulnerability among women in intimate partner relationships (including marriage) is attributable to a range of factors. Many female intimate partners of men with high-risk behaviours do not report using condoms with their husbands, and may therefore be at risk of HIV infection if their partners have unprotected sex with multiple and concurrent sex partners and/or routinely share needles and syringes with other people who inject drugs. Negotiation of sexual and contraceptive decision-making among these women, especially in the context of marriage, is influenced by **behavioural factors**, including feelings of trust, intimacy and commitment; low perception of STI or HIV risk; and a lack of communication on sexual risk and sexuality in the relationship.

A female partner's inability to refuse requests or demands for sex from her male partner and/or the use of coercive and forceful sex within the relationship also points to the important role of **social and structural factors** in influencing how these women negotiate safer sex. Among these, intimate partner violence has been identified as an important **social factor** in heightening the vulnerability of female intimate partners to HIV infection.

[72] Commission on AIDS in Asia (2008), *Redefining AIDS in Asia: Crafting an Effective Response*. (New Delhi: Oxford University Press): 51.

[73] UNAIDS, UN Women (2012), *Fact Sheet. Measuring Intimate Partner Transmission of HIV in Viet Nam: A Data Triangulation Exercise* (Ha Noi).

[74] A 2009 study in Viet Nam found that approximately one-third of men who knew they were living with HIV did not consistently use condoms with their wives, including 20 percent who did not use condoms at all. Among those who did not know the HIV status of their female partners, less than half used condoms consistently. These study populations did not include the many men living with HIV who have not yet been tested and thus do not know their status. Condom use may be even lower among this population.

[75] Mishra et al., "HIV risk behaviours."

[76] UNAIDS, *HIV Transmission in Intimate Partner Relationships in Asia:* 14.

[77] Ranjan. A. (2013), *HIV prevalence and awareness among wives of rural migrant workers of Muzaffarpur district in Bihar, India* (Ph.D. dissertation); Aryal et al. (2013), "Vulnerability to unsafe sex and HIV infection among wives of migrant workers in far western Nepal," *Journal of Chitwan Medical College* 3.3: 26–31.

[78] Though research on the subject is limited, evidence suggests that non-disclosure of HIV status leads to greater risk of infection in intimate partner relationships. For instance, non-disclosure to the intimate female partner has serious implications for *HIV transmission if the HIV-positive male partner continues to engage in unprotected sex. Source: UNAIDS, HIV Transmission in Intimate Partner Relationships in India*.

In Asia, published data from India provides the best documented evidence on the association between spousal sexual violence and increased risk for sexually transmitted infections, including HIV.[79] A 2010 study found that men reporting the highest levels of justification for intimate partner violence also reported higher levels of HIV risk behaviour (i.e. engagement in commercial sex and inconsistent condom use with their sexual partners) compared to those reporting the lowest levels of endorsement of intimate partner violence.[80] High rates of intimate partner violence indicated in these and other studies suggest that many women in Asia face harm if they attempt to refuse sex, to insist on monogamy, or to protect themselves from HIV infection by insisting on condom use.[81]

Just like women from key populations, negotiation of sex and contraceptive use among female partners of men with high-risk behaviours is mediated by a variety of factors. For these women, especially those who are married, their ability to negotiate safer sex may largely depend on cultural gender norms and practices, and not just self-perceived susceptibility to HIV infection. These **structural factors** include unequal power relations, male gender norms, and notions of masculinity that limit women's control over decisions related to sexuality. Other **structural factors** that can affect the negotiation of safer sex in these relationships include legislation that limits access to sexual and reproductive health information and services for adolescent and/or unmarried women and men, and the existence of laws that do not recognize marital rape as a crime.

Since the Commission on AIDS in Asia first highlighted the HIV vulnerabilities of female intimate partners, countries with concentrated epidemics and limited resources have found it difficult to identify and reach out to these women. Despite evidence that male-to-female intimate partner transmission of HIV accounts for up to one-third of new infections in a number of Asian countries, relatively little is known about the circumstances under which these women are able to negotiate protective behaviours with their male sexual partners. Research that explores the complex social and sexual lives of female intimate partners of men with high-risk behaviours remains scarce. A better understanding of these dynamics could help inform primary prevention programmes with men from key populations and other prevention approaches that incorporate a specific focus on intimate partner transmission of HIV.

2.5 HIV risk and vulnerability: Serodiscordant couples

HIV testing is the essential first step in identifying serodiscordant couples. Yet regional data and projections show that most people living with HIV in Asia do not know their status.[82] This poses a major challenge to intimate partner transmission prevention efforts, as knowledge of HIV status is critical to expanding access to HIV prevention, care, and treatment services. It also offers people living with HIV an opportunity to receive information and tools to protect their own health and prevent HIV transmission to others, including intimate partners. For these reasons, programmatic efforts to prevent intimate partner transmission – as well as mother-to-child transmission (PMTCT) – need to consider the factors and circumstances that place serodiscordant couples at increased risk for transmission of HIV and other STIs. These factors can be biological, behavioural, social and structural. How these factors interact may also depend on whether HIV status is known to both partners in the serodiscordant couple or only to the HIV-positive (or 'index') partner.

The *People Living with HIV Stigma Index* shows there are significant levels of sexual activity among men and women living with HIV in Asia.[83] Stigma index studies conducted among people living with HIV in Cambodia,

[79] Decker et al. (2009), "Intimate partner violence functions as both a risk marker and risk factor for women's HIV infection: Findings from Indian husband-wife dyads," *Journal of Acquired Immune Deficiency Syndromes* 51: 593–600; Weiss et al. (2008), "Spousal sexual violence and poverty are risk factors for sexually transmitted infections in women: A longitudinal study of women in Goa, India," *Sexually Transmitted Infections* 84: 133–139; Dunkle, K. L. and M. R. Decker (2013), "Gender-based violence and HIV: Reviewing the evidence for links and causal pathways in the general population and high-risk groups," *American Journal of Reproductive Immunology* 69 (Suppl. 1, 2013): 20–26.

[80] Decker et al. (2010), "Indian men's use of commercial sex workers: prevalence, condom use, and related gender attitudes," Journal of Acquired Immune Deficiency Syndromes 53: 240–246.

[81] United Nations Viet Nam (2010), *HIV Transmission from Men to Women in Intimate Partner Relationships in Viet Nam: A Discussion Paper* (Ha Noi).

[82] UNAIDS, *HIV in Asia and the Pacific*.

[83] While the studies did not always disaggregate results by gender and age, results of several surveys indicated that a higher proportion of male respondents were sexually active as compared to female respondents, although the Stigma Index survey conducted in India's Tamil Nadu state found this not to be the case where the female respondent was an HIV-positive female sex worker.

Myanmar, Nepal, Pakistan and Tamil Nadu state in India reported that a majority of male and female respondents were sexually active at the time of the study. These, and other studies from the region, indicate that many men, women and adolescents living with HIV are in relationships with others, and a significant number are part of a serodiscordant couple. A 2009 study in Viet Nam reported that serodiscordant relationships were not uncommon, with almost half of the 1,300 HIV-positive men interviewed living with an HIV-negative partner.[84] The cross-sectional multi-country Asian Internet MSM Sex Survey, conducted in 2010, reported that among the 416 HIV-positive MSM respondents, 38.9 percent had a regular partner; of these 68.5 percent had a serodiscordant or potentially serodiscordant partner.[85] This research is supported by mode of transmission analysis, which points to high levels of intimate partner transmission in long-running, concentrated epidemics of Cambodia, India, Myanmar and Thailand.

> Before I disclosed my HIV status to my wife, I did not use condoms when we had sexual intercourse. I thought that she would already be infected since we had had unprotected sex many times before. In addition, it was difficult to tell her that I would use a condom since we were just married.
>
> **30-YEAR-OLD HIV-POSITIVE MAN WHO INJECTS DRUGS, VIET NAM. CITED IN THANH ET AL. (2009).**

A number of factors increase HIV sexual transmission risk between serodiscordant couples. Of these, the viral load of the index partner is the most powerful predictor of HIV transmission. Studies have shown that there was negligible or no sexual transmission of HIV in serodiscordant couples where the index partner had an undetectable viral load or a low viral load below a given threshold.[86] This explains why access to HIV testing and counselling, effective linkages to antiretroviral treatment (ART) services, and supporting patient uptake, retention and adherence to ART are critical for preventing HIV transmission between serodiscordant couples. Other than viral load, there are important behavioural, social and structural factors that can influence the risk of HIV transmission between serodiscordant couples. For individuals living with HIV who know their status, these factors may prevent or delay disclosure to their partner, increasing the risk of intimate partner transmission. In contrast, facilitated disclosure of HIV status within an intimate partner relationship has been associated with improved engagement in HIV care for the HIV-positive partner and high adherence to ART, which in turn reduces the risk of onward transmission to the HIV-negative partner.[87] Yet, even when there is mutual knowledge of serostatus, a couple may not adopt behaviours that reduce the risk of intimate partner transmission because of behavioural issues at the individual or relationship level, social pressures and structural factors.

Despite a shortage of research looking at sexual decision-making and behaviours among serodiscordant couples in the region, available data indicates that individual and relationship-driven factors play a major role in explaining why partners may not adopt preventive behaviours.[88] Important **behavioural factors** include self-stigma and disclosure concerns (e.g. fear of rejection, isolation and of loss of intimacy), a lack of understanding about what serodiscordance means, frequency of intercourse, low rates of condom use with intimate partners, intimacy and fertility desires, and poor HIV-related health-seeking.

[84] Survey conducted by the Institute for Social Development Studies and the Vietnam Civil Society Partnership Platform on AIDS (2009, unpublished).

[85] Wei et al. (2012), "HIV Disclosure and Sexual Transmission Behaviors among an Internet Sample of HIV-positive Men Who Have Sex with Men in Asia: Implications for Prevention with Positives," *AIDS and Behavior* 16.7, October 2012: 1,970–978.

[86] Quinn et al. (2000), "Viral load and heterosexual transmission of human immunodeficiency virus type 1. Rakai Project Study Group." *New England Journal of Medicine* 342.13: 921–929; Attia et al. (2009), "Sexual transmission of HIV according to viral load antiretroviral treatment: Systematic review and meta-analysis," AIDS 23: 1,397–404.

[87] Curran et al. (2012), "HIV-1 Prevention for HIV-1 Serodiscordant Couples," *Current HIV/AIDS Reports* 9.2, Jun 2012: 160–170.

[88] Kumarasamy et al. (2010), "Risk factors for HIV transmission among heterosexual discordant couples in South India," *HIV Medicine* 11: 178-186; Mohr et al. (2013), *Risk Factors for HIV transmission in Serodiscordant Couples in Cambodia: A Case Study* (Phnom Penh: KHANA); Chakprani et al. (2007), *Sexual and Reproductive Health of People Living with HIV in India: A Mixed Methods Study* (Chennai, India: Indian Network for People Living with HIV/AIDS); Asia Pacific Network of People Living with HIV (APN+), TREAT Asia, UNESCO, UNICEF (2013), *Lost in Transitions: Current issues faced by adolescents living with HIV in Asia Pacific* (Bangkok).

How these behavioural factors influence the risk of HIV transmission between serodiscordant couples also appears to vary depending on age, gender and sexual orientation.[89] A study among HIV-positive youth in Bangkok found that male adolescents living with HIV were more likely to have a partner with unknown HIV status and less likely to disclose their HIV status to intimate partners than their female counterparts.[90] Another study in Bangkok reported that younger HIV-positive MSM were less likely to disclose their HIV status to their intimate sexual partners compared to their older MSM counterparts.[91] Such findings reinforce why prevention interventions with serodiscordant couples need to be sensitive to issues of gender, sexual orientation and age. It also underscores why dealing with behavioural factors associated with HIV testing and disclosure are critical to reducing HIV risk and vulnerability in serodiscordant couples, whatever the type of relationship.

> (A doctor) asked me… 'Where did you go and get this disease?' I did not want to tell him that I am a kothi (MSM). I told him, 'I went to a place near Chennai once. I had sex with a woman there.' Then he asked, 'Is your wife with you?' I said, 'Yes.' Immediately he said, 'You should have done all this with your wife. Otherwise HIV would not have come.' …Imagine what would have happened had I told him that I have sex with men?
>
> **INTERVIEW WITH A HIV-POSITIVE KOTHI FROM CHENNAI, INDIA. CITED IN CHAKRAPANI ET AL. (2011).**

Evidence from the region suggests a complex interaction between these behavioural factors and **social factors**. Numerous studies have confirmed the important role of stigma and discrimination in influencing sexual decision-making and behaviours of HIV-positive partners in serodiscordant relationships. This includes stigma within family, local community and health care settings. For HIV-positive partners who belong to a key population group, having HIV means they face a 'double stigma', which can prevent them from disclosing their HIV status to intimate partners and from seeking and adhering to treatment, thereby increasing the risk of intimate partner transmission.[92]

Other **social and cultural issues** – particularly marital and fertility pressure – can influence the risk of HIV transmission between serodiscordant couples. Research conducted in India and China shows that parents expect their children to get married, and thus in many cases people who are HIV-positive – men in particular – do not reveal their status due to stigma. These marriages result in the formation of serodiscordant couples; and while the HIV-positive partner may attempt to protect their spouse from infection by practicing safe sex, there is soon pressure on the couple from parents and society for children.[93] Even if both partners have knowledge of their serostatus, social and familial pressure can be an overriding factor in their sexual decision-making, including the decision not to adopt protective behaviours.

> Men who have sex with men in India are criminalized, social outcasts and many times married to women due to family and societal pressures. The hardest thing for them might be to tell their spouses their HIV status. While this is difficult, this is not impossible; and addressing the issue does not have to compete with funds for HIV prevention with key populations.
>
> **ASHOK ROW KAVI, CHAIRPERSON OF THE HUMSAFAR TRUST, AN NGO BASED IN MUMBAI, INDIA.**

[89] Apoorva et al. (2013), "Risky Behaviors among HIV-Positive Female Sex Workers in Northern Karnataka, India, *AIDS Research and Treatment*, article ID 878151; Rongkavilit et al. (2007), "Health Risk Behaviors among HIV-Infected Youth in Bangkok, Thailand," *Journal of Adolescent Health* 40.4, Apr 2007: 358. e1–.e8; Edwards-Jackson et al. (2012), "HIV serostatus disclosure is not associated with safer sexual behavior among HIV-positive men who have sex with men (MSM) and their partners at risk for infection in Bangkok, Thailand," *AIDS Research and Therapy* 9.1: 38.

[90] Rongkavilit et al., "Health Risk Behaviors among HIV-Infected Youth in Bangkok."

[91] Edwards-Jackson et al., "HIV serostatus disclosure is not associated with safer sexual behavior."

[92] Global Network of People Living with HIV/AIDS (GNP+)/ICW Global/IPPF/UNAIDS (2011), *The People Living with HIV Stigma Index: Asia Pacific Regional Analysis* 2011 (Bangkok); Chakrapani et al. (2011), "Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India," *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV* 23.12 (2011): 1,687–694; Kimmons (2014), *HIV Rising Among Men Having Sex with Men in Vietnam* (Thomas Reuters Foundation).

[93] Solomon and Solomon, "HIV serodiscordant relationships in India: Translating science into practice," *Indian Journal of Medical Research* 134 (Dec 2011), 904–911; Steward et al., "Charting a Moral Life: The Influence of Stigma and Filial Duties on Marital Decisions among Chinese Men who Have Sex with Men," *PLoS ONE* 8.8 (2013): e71778.

Structural-level discrimination, such as lack of laws protecting the rights of people living with HIV and criminalization of HIV transmission and exposure, may also play an important role in influencing the risk of intimate partner transmission. Such discrimination can create an environment where disclosing one's HIV-positive status is perceived as a risky act by the individual. A 2010 study looking at sexual transmission behaviours among men who have sex with men in Asia found that countries with the highest reported non-disclosure rates had enacted or proposed laws to criminalize HIV transmission and exposure.[94] Global analysis supports the view that criminalization of HIV transmission does not prevent intimate partner transmission, or reduce the risk of transmission between serodiscordant couples.[95] Even when disclosure has taken place, other **structural factors** can influence the risk of HIV transmission between serodiscordant couples. In many cultural contexts, **gender inequities and traditional gender roles** influence sexual negotiation practices among serodiscordant couples, often making it difficult for intimate partners to negotiate condom use and sexual activity. Other structural barriers that can influence the risk of HIV transmission between serodiscordant couples include the cost of and poor access to HIV treatment and other health services, which may delay HIV-positive individuals from beginning ART, leading to higher viral loads – which in turn increases the risk of transmission to their intimate partners/spouses.[96]

The dynamics of serodiscordant relationships are complex. Biological, behavioural, social and structural factors combine to increase the risk of HIV transmission between serodiscordant couples, although the way these interrelate may depend on the age, gender and sexual orientation of the partners. These factors work directly and indirectly to influence sexual behaviour and practices within a serodiscordant relationship. This includes sexual negotiation, disclosure of HIV-status to intimate partners, HIV-related health-seeking, and patient retention and adherence to ART. Despite these complexities and limitations of data, available evidence suggests that focusing attention on individuals who know they are HIV-positive may be one of the most effective ways of reducing HIV transmission and preventing intimate partner and mother-to-child transmission. This strategy is known as 'Positive Prevention', although it has also been called 'Prevention with Positives' and, most recently, 'Positive Health, Dignity, and Prevention'.[97]

[94] Wei et al., "HIV Disclosure and Sexual Transmission Behaviors."

[95] UNAIDS/UNDP (2008), *Criminalization of HIV Transmission Policy Brief* (Geneva); ATHENA (2009), *10 reasons why criminalization of HIV exposure or transmission harms women*, at http://www.athenanetwork.org/resources.html.

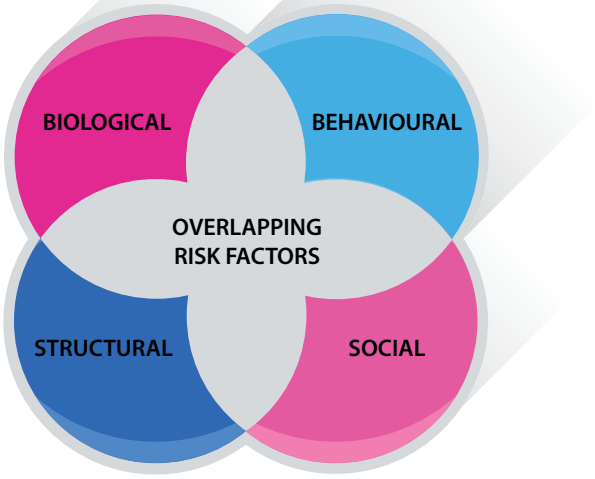
[96] Spino, A., M. Clark, and S. Stash (2010), *HIV Prevention for Serodiscordant Couples* (Arlington, Virginia: USAID/AIDSTAR-One).

[97] GNP+ and UNAIDS (2011), *Positive Health, Dignity and Prevention: A Policy Framework* (The Netherlands).

Determinants of HIV risk and vulnerability in serodiscordant couple relationships

- Viral load of the HIV- positive partner

- Self-stigma
- Concerns over disclosure of HIV-positive status (fear of rejection, isolation and of loss of intimacy)
- Lack of understanding about what serodiscordance means
- Low or inconsistent condom use with intimate partners (and associated issues around trust and fidelity when introducing condoms into these relationships)
- Intimacy and fertility desires
- Poor health seeking



- Gender inequities and traditional gender roles that make it difficult for intimate partners to negotiate condom use and sexual activity
- Lack of laws protecting the rights of people living with HIV
- Criminalization of HIV transmission and exposure
- Low or inconsistent condom use with intimate partners (and associated issues around trust and fidelity when introducing condoms into these relationships)
- Cost of, and poor access to, HIV treatment and other health services, STI, HIV and SRHR information and services

- HIV-related stigma occurring in family and community settings
- Fear of 'double stigma' if the HIV-positive individual also belongs to a key population group
- Relationship – driven issues , including unequal power within intimate partner relationships and intimate partner violence
- Marital and fertility pressure from families and society
- Stigma and discrimination in health care settings

BOX 3 KNOWING YOUR EPIDEMIC: DEVELOPING THE EVIDENCE BASE FOR INTIMATE PARTNER TRANSMISSION THROUGH RESEARCH

As part of 'knowing your epidemic', it is important that relevant data and research on sexual risk behaviour and sexual decision-making among key populations and serodiscordant couples are used to develop effective prevention programming and allocate resources. Based on the analysis presented in this chapter and the context of the region's epidemic, the following research activities could help to strengthen the evidence base for intimate partner transmission of HIV in Asia:

- Address research gaps identified from national reviews or reports. Particular attention should be paid to gaps in research pertinent to intimate partner transmission. This includes research and analysis related to male clients of sex workers, men who have sex with men, transgender women, women who inject drugs and serodiscordant couples.
- Continue and expand operational research to understand and document HIV risk behaviours among male, female and transgender key populations, particularly within the context of their intimate partner relationships and across age groups. Ensure this operational research is led by – or at a minimum conducted in partnership with – key population communities, reaching out to their intimate partners where it is considered appropriate and practical to do so.
- Undertake research on sexual risk behaviours and sexual decision-making within serodiscordant relationships where HIV status is known (by one and/or both partners). This can help to identify the different factors that influence contraceptive uptake, reproductive choices, and sexual behaviour among male, female and transgender adults and adolescents in serodiscordant couples, as well as their needs in relation to HIV, sexual and reproductive health, and other health concerns. Programmers and practitioners can use this information to strengthen interventions with serodiscordant couples and scale up Positive Health, Dignity, and Prevention approaches. This, in turn, can help to prevent both sexual and vertical (PMTCT) transmission within intimate partner relationships.
- Commission research to examine how intimate partner and other types of violence experienced by women from key populations may increase their risk of HIV, including within their intimate partner relationships.
- Conduct periodic gender assessments of the country's HIV response and use these findings to inform interventions to reduce and prevent intimate partner transmission. In concentrated epidemics, these assessments should identify the gender needs and gaps in:
  1) Existing HIV-related services relating to male, female and transgender key populations and their sexual partners
  2) Existing HIV-related services for men, women, adolescents, and girls and boys living with HIV, as well as serodiscordant couples
  3) National programmes and policies that facilitate or hinder participation in and access to HIV-related services (including SRHR, MCH, PMTCT, and violence response services) by these groups.

FUNDING OPPORTUNITIES FOR COUNTRIES: Funding to support these types of operational research can be included as part of funding applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria, noting that most Asian countries allocate far less than the recommended 5–10 percent of their HIV grant budgets to monitoring and evaluation activities.

High-impact strategies to prevent intimate partner transmission of HIV in Asia

3

3.1 Intimate partner transmission of HIV in Asia

Effective prevention programming and resource allocation requires knowledge of transmission patterns. Yet, in assessing the seriousness of intimate partner transmission, establishing the evidence base continues to be problematic. Efforts to improve regional understanding of this issue through data synthesis and modelling have highlighted a number of challenges, as well as gaps, in country data.[98] Key challenges relate to difficulties with definitions, incomplete data and assumptions, and the need to strengthen surveillance and size estimation studies. Major gaps include those in the quality of available data sources and data on risk behaviour (these are discussed in detail under section 1.6). Yet a problematic evidence base is not limited to the issue of intimate partner transmission. The evidence base remains incomplete on other elements of prevention programming as well.[99] This has not deterred Asian countries from undertaking a range of prevention activities, nor should it prevent them from developing a programmatic response to intimate partner transmission of HIV.

National data on intimate partner transmission of HIV in Asia

- In 2013, it was estimated that 37 percent of new HIV infections in **Cambodia** will occur through spousal transmission.[100]
- Of the estimated 48,000 new HIV infections in **China** in 2011, heterosexual transmission accounted for 52.2 percent. Of those infected through heterosexual transmission, approximately 25 percent were infected through spousal sexual contact.[101]
- Evidence suggests that the primary risk factor for HIV in married women in **India** is their spouses' involvement in extramarital or paid sex.[102]
- In **Indonesia**, as the epidemic has matured there has been a shift in the main mode of transmission from injecting drug use to sexual transmission. In the coming years, the second largest number of new HIV infections is predicted to occur amongst women classified as 'general population' or 'low-risk'. It is estimated that a significant proportion of these infections will be a result of intimate partner transmission of HIV. According to epidemic modelling, substantial numbers of HIV infections will also occur amongst men who are clients of sex workers, men infected via intimate partner transmission from their female intimate partners/wives, as well as men who had engaged female sex workers in earlier years.[103]
- In **Myanmar**, the latest data shows significant numbers of new infections (more than 60 percent) occurring among MSM, men who inject drugs, and sex workers and their clients. However, a large proportion of new infections (almost 40 percent) are also estimated to occur among women and men at lower risk of HIV infection, probably within the context of intimate partner relationships and primarily the partners of current and former sex workers, MSM and people who inject drugs.[104]
- In **Thailand**, an estimated 23 percent of all new HIV infections between 2012 and 2016 are occurring through spousal transmission.[105]

98 United Nations Viet Nam, *HIV Transmission from Men to Women*.

99 UNAIDS (2010), *Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections. A UNAIDS Discussion Paper* (Geneva), p. 32.

100 National Centre for HIV/AIDS, Dermatology, and STDs and partners (2011), *HIV Estimation and Projection 2011, Cambodia* (Phnom Penh).

101 Ministry of Health, People's Republic of China/UNAIDS/WHO (2011), *Estimates for the HIV/AIDS Epidemic in China* (Beijing).

102 UNAIDS, *HIV Transmission in Intimate Partner Relationships in India*.

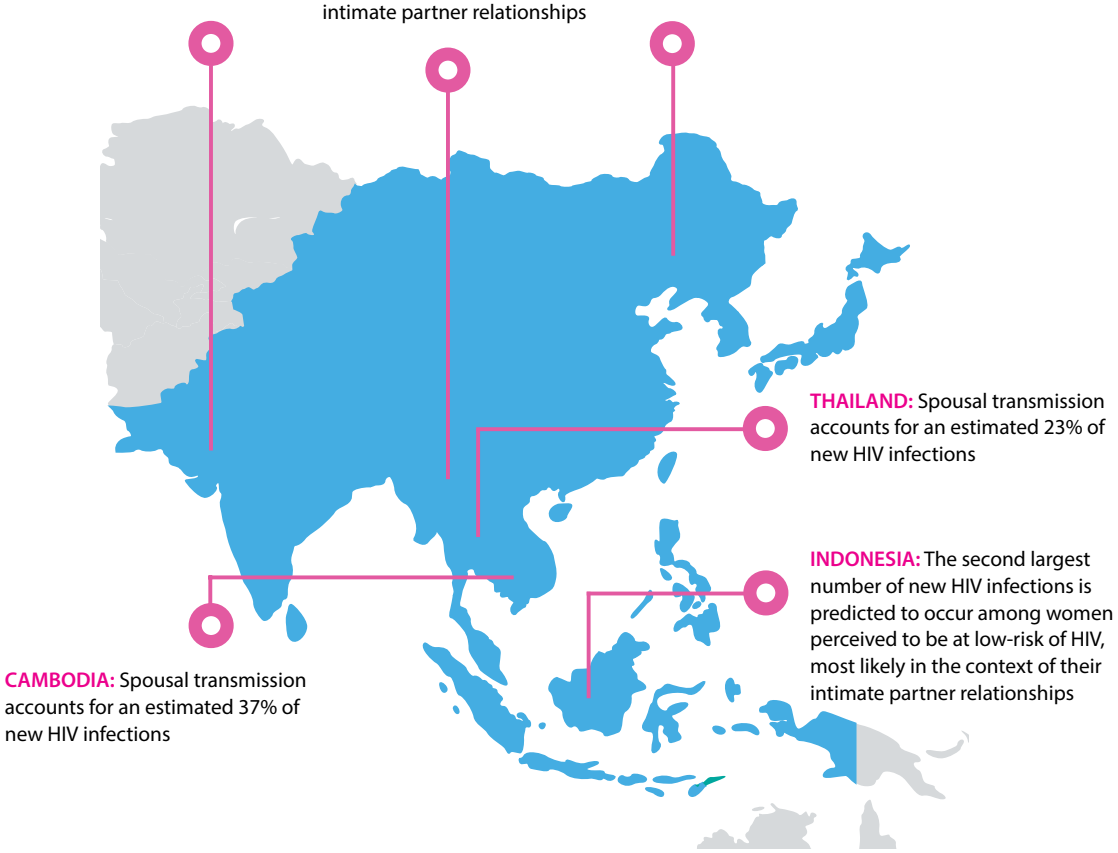
103 Indonesian National AIDS Commission (2013) *2011 UN General Assembly Political Declaration on HIV and AIDS: Mid-Term Review Report of the 'Ten Targets' in Indonesia* (Jakarta).

104 National AIDS Programme, Myanmar/Strategic Information and M&E Working Group (2012), *HIV Estimates and Projections Asian Epidemic Model Myanmar 2010–2015* (Yangon).

105 See http://www.aidszeroportal.org.

- In **Viet Nam**, HIV prevalence among the female sexual partners of men who inject drugs has found to be high (about 14 percent) in several provinces, rising to 30 percent in Ho Chi Minh City. In Ha Noi and Dien Bien, the primary risk factor for women is sex with a male intimate partner who injects drugs.[106]

Epidemic modeling shows that countries in the region with mature, concentrated epidemics have high levels of intimate partner transmission of HIV



[106] Hammett et al. (2012), *HIV risk and HIV prevention among female sexual partners of IDUs in Viet Nam* (Ha Noi); Poster Exhibition XIX International AIDS Conference: Abstract no. WEPE326.

BOX 4 KNOWING YOUR EPIDEMIC: RECOMMENDATIONS FOR STRENGTHENING EPIDEMIOLOGICAL DATA COLLECTION AND ANALYSIS RELATED TO INTIMATE PARTNER TRANSMISSION OF HIV

Improving the evidence base for intimate partner transmission of HIV needs to take, as its starting point, improved data on key populations (including clients of sex workers) and their risk behaviours. This includes:

- Ensuring national surveillance protocols integrate population size estimations for male, female and transgender key populations. Size estimations of key populations are critical for being able to assess the significance of intimate partner transmission. For example, knowing the size of male key populations, as well as the types of intimate relationships these populations engage in, can provide an indication of how many people may be at risk of HIV through their intimate partner relationships.
- Ensuring that data related to key populations is disaggregated by gender and age as standard practice, and reported on as such. This includes reporting sex worker and injecting drug user data by female, male and (where possible) transgender categories, and by age group.
- Undertaking a systematic analysis of existing data from behavioural surveillance surveys (such as the BSS and IBBSS) to extract information that may be relevant to understanding the dynamics of intimate partner transmission within particular populations.
- Ensuring that behavioural surveillance surveys of selected risk populations (e.g. the BSS and IBBSS) include questions about their regular partners for the specific purpose of better understanding risk behaviour within the context of intimate partner relationships. As part of this, questions about intimate partner violence can be routinely incorporated into the BSS and IBBSS. The BSS and IBBS can also survey the existence and extent of violence against key populations, including the type and average frequency of violence and who are the perpetrators.

3.2 Towards a combination prevention approach

The goal of combination prevention is to reduce transmission of HIV by implementing a combination of biological, behavioural and structural interventions that are carefully selected to meet the needs of a population.[107] Combination prevention is not a new concept but an existing approach to prevention already recognized within National HIV Strategic Plans across the region. In the context of intimate partner transmission, combination prevention involves the strategic, coordinated use of different types of prevention activities for interventions that operate on multiple levels. In concentrated epidemics, this means interventions to prevent intimate partner transmission need to work at different levels to address the specific but diverse needs of key populations and their intimate sexual partners, as well as those in serodiscordant relationships.

UNAIDS DEFINES COMBINATION PREVENTION PROGRAMMES AS:

…rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections. Well-designed combination prevention programmes are carefully tailored to national and local needs and conditions; focus resources on the mix of programmatic and policy actions required to address both immediate risks and underlying vulnerability; and they are thoughtfully planned and managed to operate synergistically and consistently on multiple levels (e.g. individual, relationship, community, society) and over an adequate period of time.

UNAIDS, *Combination Prevention: Strategic HIV prevention programmes founded on good practice. A background paper for the UNAIDS Prevention Reference Group Meeting;* 3–5 December 2009, Geneva.

[107] USAID/PEPFAR (AIDSTAR-One), *Combination Approaches: An Overview of Combination Prevention*, at http://www.aidstar-one.com/focus_areas/prevention/pkb/combination_approaches/overview_combination_prevention.

As part of this combination prevention approach, types of intervention strategies that can combine to address HIV risk and vulnerability in intimate partner relationships are:

- **Biomedical interventions:** These directly influence the biological systems through which HIV infection is transmitted, such as blocking infection (e.g. provision of male and female condoms) or decreasing infectiousness (e.g. ARV-related prevention).
- **Behavioural interventions:** These include a range of sexual behaviour change communication programmes designed to encourage men and women to reduce behaviours that increase risk of HIV and increase protective behaviours (e.g. promoting partner reduction, correct and consistent condom use, uptake of HIV testing and counselling, and interpersonal communication).
- **Structural interventions:** These address important social, cultural, legal and political factors that contribute to the spread of HIV (e.g. reducing stigma and discrimination, legal and policy reforms, addressing gender-based violence, and transforming harmful gender norms).

In today's funding environment, efforts need to be focused on targeted investments in the right places and on programmes that can generate the greatest impact with limited resources. Based on the regional context, this chapter presents five high-impact strategies that can prevent HIV transmission in intimate partner relationships in Asia:

STRATEGY 1: Ensure existing primary HIV prevention efforts with key populations and reach out to their intimate partners with information, referrals and services.

STRATEGY 2: Ensure services that integrate HIV and sexual and reproductive health and rights (SRHR) reach both key populations and their intimate partners, building on existing HIV and SRHR programming.

STRATEGY 3: Use new, proven biomedical interventions (such as antiretroviral-related prevention) to prevent HIV transmission from HIV-positive individuals to their intimate partners.

STRATEGY 4: Increase the involvement of male intimate partners in integrated antenatal care, MCH, and PMTCT services.

STRATEGY 5: Reform laws and policies that hinder efforts to reach the intimate partners of key populations and people living with HIV with information and services.

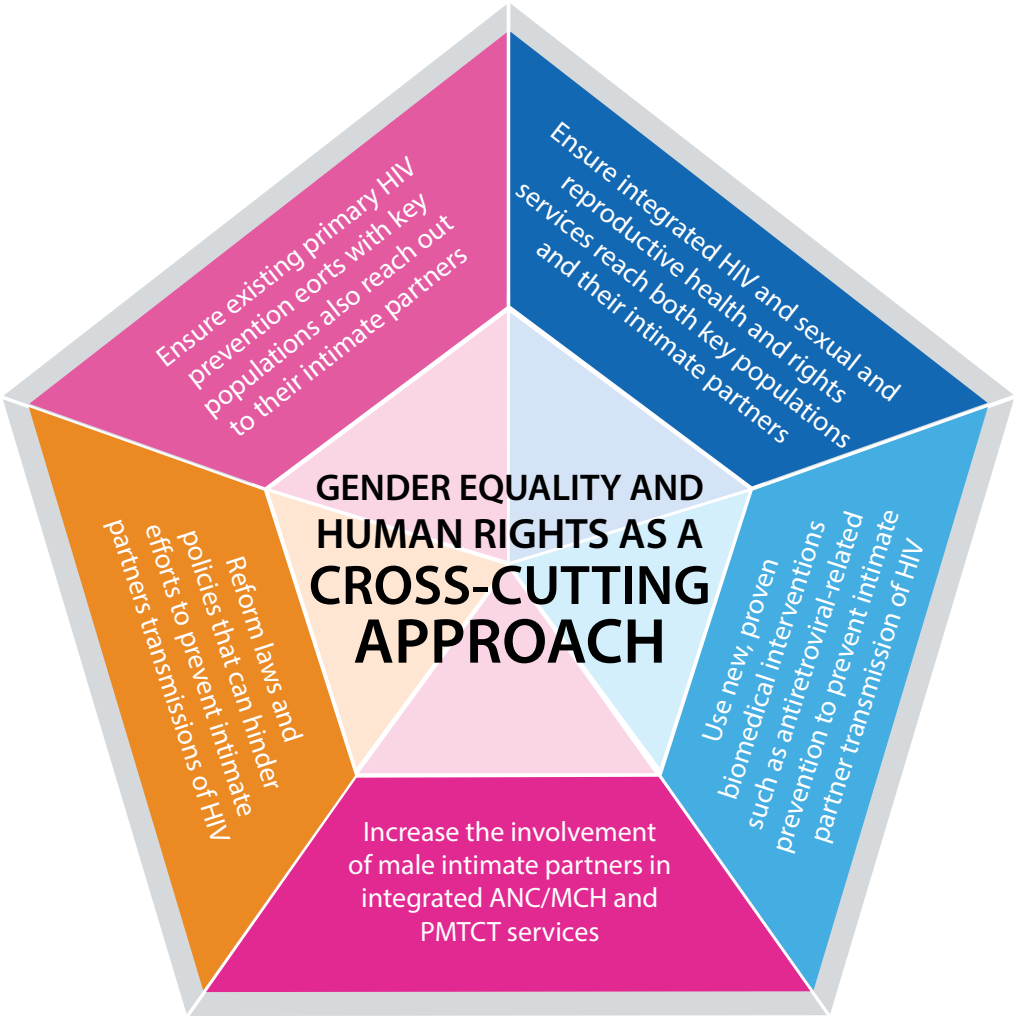
GENDER EQUALITY AND HUMAN RIGHTS AS A CROSS-CUTTING APPROACH:

A gender equality and rights-based approach requires that interventions to prevent intimate partner transmission of HIV are implemented in a way that fosters human rights protection, reduces stigma and discrimination, and encourages the engagement of adult and adolescent key populations and people living with HIV.

The rest of this chapter describes the evidence-based application of each strategy and important considerations for implementation.[108] Wherever possible, programmatic approaches and/or policy examples are cited to illustrate how this strategy is being implemented in the region. Following the combination prevention approach, these strategies can be implemented in a coordinated way, simultaneously. For example, addressing intimate partner transmission in primary HIV prevention efforts with key populations can work at the same time that health providers offer and expand integrated HIV/SRHR services to these communities.

[108] The evidence for the impact of interventions to reduce and prevent intimate partner transmission is still emerging. Therefore, in relation to specifically preventing intimate partner transmission, several of the strategies described should be considered as promising.

Combination prevention: 5 high-impact strategies for preventing HIV transmission in intimate partner relationships



The IPT Jigsaw: Components of a 'combination prevention' approach for preventing HIV transmission in intimate partner relationships

Key to colour shading

STRATEGY #1
Ensure existing primary HIV prevention efforts with key populations and reach out to their intimate partners with information, referrals and services.

STRATEGY #2
Ensure services that integrate HIV and sexual and reproductive health and rights (SRHR) reach both key populations and their intimate partners.

STRATEGY #3
Use new, proven biomedical interventions (such as antiretroviral-related prevention) to prevent HIV transmission from HIV positive individuals to their intimate partners.

STRATEGY #4
Increase the involvement of male intimate partners in integrated antenatal care, maternal and child health, and prevention of mother-to-child transmission of HIV services.

STRATEGY #5
Reform laws and policies that hinder efforts to reach the intimate partners of key populations and people living with HIV with information and services.

3.3 Strategy 1: Ensure existing primary prevention efforts with key populations also reach out to their intimate partners

Depending on the population group and local context, various strategies can be used within primary HIV prevention efforts to provide key populations with the skills (e.g. communication-skills training, relationship education) and tools (e.g. contraceptives) to protect themselves and their intimate partners. This requires adding or integrating new components related to intimate partner transmission of HIV into primary prevention interventions with adult and adolescent males and females from key populations, including comprehensive condom and lubricant programming, STI and HIV testing and counselling, comprehensive harm reduction programming, and behavioural change interventions. Specific components may comprise: provision of commodities, such as free condoms and water-based lubricants; individual, couple, and/or group counselling; safer sex communication; life-skills education; and the provision of information and advice to key populations and their intimate partners. To be effective, these interventions need to be anchored in human rights, guided by the range of obligations already agreed to by Member States. This requires that the rights of key populations to voluntary and informed consent, privacy and confidentiality are respected when reaching out to intimate partners/spouses with information, referrals, and services.

IMPORTANT REFERENCE DOCUMENTS AND RESOURCES FOR COUNTRIES:

WHO (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. Geneva.

UNAIDS, UNFPA, Asia Pacific Network of Sex Workers (2012), *The HIV and Sex Work Collection: Innovative responses in Asia and the Pacific* (Bangkok).

WHO (2012), *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. 2012 Revision* (Geneva).

WHO (2011), *Guidelines: Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: Recommendations for a public health approach* (Geneva).

Addressing intimate partner transmission of HIV within comprehensive condom and lubricant programming

Evidence-based application: Evidence shows that consistent and correct use of male condoms reduces sexual transmission of HIV and other STIs by up to 94 percent.[109] Use of water- or silicone-based lubricants helps to prevent condoms from breaking and slipping; and while less data is available on female condoms, evidence suggests that the use of female condoms also prevents HIV and STIs.[110] Government-supported interventions involving condom promotion in Asia have had considerable success; female sex workers in the region reported a median of 80 percent condom use during the last sexual encounter with clients.[111] Despite these achievements, however, condom use among men and women from key populations in Asia still remains consistently lower with intimate partners/spouses than with casual and commercial partners.[112] This shows that even where men and women from key populations have access to free condoms and lubricants through targeted distribution, relationship factors can prevent them from using these with intimate partners, particularly in marriage, where condom use may raise issues of distrust and accusations of infidelity. Therefore, explicit attention needs to be given to negotiating condom use with intimate partners. This is in line with WHO guidelines (2014) recommending that "along with promotion and supply, programmes for key populations should offer information and skills-building in negotiating condom use." A growing body of evidence from the region indicates that peer-led and outreach approaches may help to increase knowledge, develop skills, and empower adult and adolescent key populations to use condoms and

[109] WHO (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (Geneva).

[110] Ibid.

[111] UNAIDS, *HIV in Asia and the Pacific*.

[112] Petruney et al. (2012), "Meeting the Contraceptive Needs of Key Populations Affected by HIV in Asia: An Unfinished Agenda," *AIDS Research and Treatment*: article ID 792649.

lubricants consistently with their intimate partners.[113] There are also examples of comprehensive condom programmes that engage the intimate partners and spouses of men from key populations, particularly men who inject drugs.[114]

Implementation considerations: Comprehensive condom programming with key populations – and attempts to engage their intimate partners – needs to address the challenges associated with negotiating condom use in marriage/intimate partner relationships and issues of intimate partner violence. Studies have shown that discussion of condom use with intimate partners needs to be handled discreetly in order to respect the private lives of key populations, especially where their behaviours are criminalized.[115]

EXPERIENCES FROM THE REGION

In **Myanmar**, community outreach workers from the *Targeted Outreach Program* (TOP), initiated by Population Services International, use examples from their own intimate partner relationships to engage in targeted counselling with sex workers around the need to protect oneself in these types of relationships. In doing so, these outreach workers have developed communication methods to effectively discuss negotiation of condom use with intimate partners, without intruding on a sex worker's private life. Across parts of **India**, alongside the provision of free condoms and lubricant to MSM, transgender and third gender communities, some condom promotion programmes provide additional services to support correct and consistent condom use within intimate partner relationships. Within its programmes, the *Humsafar Trust* in Mumbai adopts a comprehensive approach to sexuality that includes specific initiatives to address the needs of married MSM and their female partners. Interventions include comprehensive and skills-building information about condom use and negotiation. As part of a targeted condom distribution programme with men who inject drugs, local NGOs such the *Nai Zindagi Trust* in **Pakistan** and *Supporting Community Development Initiatives* in **Viet Nam** have been able to reach intimate partners with information and commodities, while also respecting and upholding the rights of people who inject drugs. In both countries, efforts have been aided by establishing collaborative linkages with the National AIDS Programme and Ministry of Health.

Reaching out to intimate partners in STI and HIV testing and counselling among key populations

Evidence-based application: Quality HIV testing and counselling (HTC) can help prevent HIV infection in men and women from key populations by discouraging high-risk behaviours and supporting the protective behaviours of injecting and sexual partners, including their intimate partners/spouses. Individuals who learn they are HIV-positive through HTC can also be empowered to take steps to decrease the risk of intimate partner transmission of HIV. A recent multi-country randomized control study showed that providing couples-oriented, post-test HIV counselling increased partner-testing rates compared with standard counselling.[116] As primary prevention efforts with key populations seek to increase the uptake of STI and HTC services, neglecting partners in these interventions may be a missed opportunity for prevention of intimate partner transmission.

> An MSM sought STI treatment but he did not reveal his marital status to his doctor. Even after completing the full course of treatment, he got the symptoms again because his wife had also got infected but she had not been treated. So it is a major area that needs to be addressed.
>
> **NGO SERVICE PROVIDER, BHUBANESWAR, INDIA CITED IN CHAKRAPANI ET AL. (2011).**

[113] UNAIDS, UNFPA, Asia Pacific Network of Sex Workers (2012), *The HIV and Sex Work Collection: Innovative responses in Asia and the Pacific* (Bangkok); WHO, UNFPA, UNAIDS, NSWP, World Bank (2013), *Implementing comprehensive HIV/STI programmes with sex workers: Practical approaches from collaborative interventions* (chapter 4), (Geneva); UNODC (2010), "Prevention of Sexual Transmission of HIV for Women who Use Drugs and the Spouses of Male Drug-Users: Negotiating Condom Use in the Context of Drug Use in South Asia," in *Prevention, Treatment and Care for Female Drug Users/Injecting Drug Users and Female Prisoners in Pakistan: Information Briefs* (Islamabad).

[114] UNODC, National AIDS Control Organisation, India, *Female Injecting Drug Users*.

[115] WHO et al., *Implementing comprehensive HIV/STI programmes*.

[116] Orne-Gliemann et al. (2013), "Increasing HIV testing among male partners: The Prenahtest ANRS 12127 multi-country randomized trial," AIDS 27: 1,167–177.

EXPERIENCES FROM THE REGION

Despite the limited evaluation of individual programmes from an intimate partner transmission perspective, there are examples of effective interventions in which key populations who access STI and HIV testing and counselling services receive tailored prevention messages about partner testing and disclosure and/or are supported to bring in their spouse/intimate partner for testing. Many of these are community-led HIV programmes working with men who inject drugs and men who have sex with men who are married or have female intimate partners. In several countries, including **Cambodia** and **Thailand**, the Ministry of Health complements these efforts through the use of counselling tools that promote partner testing in public health facilities.

Source: Nai Zindagi Trust (2010), *Final Technical Report: HIV prevention, HIV and AIDS diagnostics, treatment, care and support services for married injecting drug users, their wives and children.* (Islamabad); UNDP (2012), *A report on addressing the SRH needs of MSM and their female partners using existing SRH facilities and/or working in collaboration with existing organizations* (New Delhi).

Implementation considerations: While there is consensus that the criminalization of transmission and non-disclosure undermines human rights while serving little public health benefit, there is less clarity about the ethics of third-party notification, especially in resource-constrained settings.[117] Despite initiatives with key populations to encourage voluntary HIV disclosure and to increase partner testing, regional research shows that partner notification by health care workers without the patient's consent is still commonplace.[118] This reaffirms the importance of sensitizing staff at STI/HIV and antenatal clinics on the vulnerabilities and rights of key populations so that they can protect and promote the health and human rights of both the client and the intimate partner. To this end, whenever appropriate and feasible, mutual disclosure of HIV test results under the guidance of a counsellor should be encouraged and facilitated.[119] Health care workers should also be sensitive to supporting men and women from key populations to test alone without their partners if they fear gender-based violence.[120] In such circumstances, partner testing for HIV and other STIs may need to occur without disclosure.

Reaching out to intimate partners within comprehensive harm reduction programming

Evidence-based application: A comprehensive package of evidence-based interventions to reduce harms associated with injecting drug use is already available to policymakers and programmers.[121] Several components of this comprehensive harm reduction package are directly relevant for preventing intimate partner transmission. These include interventions to provide condom programmes for people who inject drugs and their sexual partners (addressed in the section above) and targeted information, education and communication for people who inject drugs and their sexual partners.[122] For example, needle and syringe programmes aim to engage their clients on a regular basis, and this provides multiple opportunities for harm reduction programmes to facilitate access to other health and support services, not just for the client but for their intimate partner as well.

[117] Bott and Obermeyer (2013), "The social and gender context of HIV disclosure in sub-Saharan Africa: A review of policies and practices," *SAHARA Journal* 10.1, Jul 2013: S5–S16.

[118] Numerous reported instances of health care workers undertaking partner notification without a patient's consent are documented in APN+ et al., *Lost in Transitions;* APN+ (2012), *Positive and Pregnant: How Dare You?* (Bangkok); GNP+/ICW Global/IPPF/UNAIDS, *The People Living with HIV Stigma Index;* and UNDP, WAP+, APN+, SAARCLAW (2013), *Protecting the rights of key HIV-affected women and girls in health care settings: A legal scan. Regional report* (Bangkok).

[119] WHO (2012), *Guidance on Couples HIV Testing and Counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for public health approach* (Geneva).

[120] WHO (2013), *Global update on HIV treatment 2013: Results, impact and opportunities* (Geneva).

[121] WHO (2012, Revised), *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* (Geneva).

[122] Ibid.

EXPERIENCES FROM THE REGION

Young people who inject drugs face additional risks and barriers to services, which can make it harder to reach out to their intimate partners. Consequently, they may require specific and more creative engagement strategies to promote uptake of services and to ensure their rights are fully respected and protected when reaching out to intimate partners. In **Nepal** the Youth Chapter of the local NGO *Aavash Samuha* promotes a youth-friendly, comprehensive approach to HIV, including harm reduction, treatment, care and support. The NGO uses outreach workers of the same age and background to increase uptake of essential prevention commodities (including male and female condoms) among young women who inject drugs. As part of these prevention activities, the Aavash Samuha Youth Chapter (with the women's permission) also reaches out to male friends and intimate partners with information and invitations to attend support group meetings.

Implementation considerations: Regional research highlights several challenges in reaching out directly and indirectly to female intimate partners and spouses of men who inject drugs.[123] Studies have shown that some men do not wish to bring their wives to drop-in centres as they are predominantly occupied by men who inject drugs; other men do not want to disclose their HIV or STI status to their wife; and some men who inject drugs might already be separated or divorced from their wives.[124] These challenges can be minimized through community-based outreach. This evidence-based model is a highly effective means of delivering primary HIV prevention to people who inject drugs, such as needle and syringe programmes, condom programmes, and targeted communication, and also serves as a useful access point for referral to other services, including ART.[125] As part of comprehensive harm reduction programming, programmatic experience indicates that community-based outreach can also successfully address intimate partner transmission and reach the intimate partners of people who inject drugs.

Reaching out to intimate partners in community-level behavioural change interventions

Evidence-based application: Behavioural change interventions often focus on individual behaviours, particularly condom use and HIV/STI testing. However, initiatives can also operate at the community level to address the social (stigma, discrimination, violence) and structural (gender inequality norms, legal environment) factors that affect individual sexual decision-making and behaviour, including negotiation of safer sex with intimate partners. Community-level behavioural change interventions are particularly important for prevention of intimate partner transmission. This is because HIV risk and vulnerability within intimate partner relationships is influenced by social and structural, as well as behavioural, factors. Programmatic evidence from the region shows such interventions can empower adult and adolescent key populations to protect both themselves and their intimate partners against HIV infection. This type of intervention has also been able to directly engage intimate partners.

Implementation considerations: Community-level behavioural change interventions may be delivered as part of other primary HIV prevention efforts. They may take place face-to-face through community outreach and education activities or through mass media. WHO guidelines recommend that the selection of content, approach and medium should be based on a good formative analysis of the local situation.[126] At a minimum, this requires the participation of key populations and relevant community networks in developing and delivering messages.

[123] UNODC (2010), Prevention, *Treatment and Care for Female Drug Users/Injecting Drug Users and Female Prisoners in Pakistan: Information Briefs* (Islamabad); UNODC, National AIDS Control Organisation, India, *Female Injecting Drug Users*.

[124] UNODC Regional Office for South Asia (2012), *Access to comprehensive package of services for injecting drug users and their female sex partners: Identification and ranking of barriers in Northeast India* (New Delhi).

[125] WHO, *Consolidated guidelines*.

[126] WHO, *Consolidated guidelines*.

EXPERIENCES FROM THE REGION

In **Pakistan**, NGO-led and government-supported initiatives with married, street-based men who inject drugs are successfully incorporating issues of male responsibility towards their wives and families within HIV and harm reduction programming. In addition to condom distribution, these outreach programmes provide information on sexual health and STI testing, as well as address other aspects of male sexual and reproductive health, such as sexual counselling, to provide men who inject drugs with the information and negotiation skills to adopt safer sex practices with their intimate partners/spouses. In **Viet Nam**, specific efforts are being made to reach the female intimate partners of men who inject drugs in several provinces with high HIV prevalence related to drug use. Through community-based outreach, partners and spouses are able to receive sexual risk reduction counselling, HIV testing and counselling with support for mutual disclosure of HIV status, and effective referrals to treatment and family planning services. Elsewhere, projects have shown that the establishment of female-friendly and/or women-only drop-in centres can be an effective way to reach women who inject drugs and female partners of men who inject drugs with information, services and referrals. In **Cambodia**, the local NGO KHANA designs services for partners of people who use drugs, including SRHR, condom distribution, family support and tailored HIV prevention, education and counselling services. Female partners attend drop-in centres and can seek counselling and psychosocial support from staff.

Source: Nai Zindagi Trust, *Final Technical Report* and UNODC, *Prevention, Treatment and Care for Female Drug Users*; Hammett and Khuat (2014), *HIV Prevention for Female Sexual Partners of People Who Inject Drugs (PWID) in Vietnam* (Abt Associates, Inc.); Hammet et al. (2012), "HIV prevention interventions for female sexual partners of injection drug users in Hanoi, Vietnam: 24-month evaluation results," *AIDS and Behavior* 16: 1,164–172; International HIV/AIDS Alliance et al. (2014), *Lessons Learned from HIV and AIDS Work with People Who Use Drugs in Asia and Eastern Europe* (Brighton, UK).

EXPERIENCES FROM THE REGION

The Ashodaya Samithi sex worker collective of Mysore, **India**, has become a model of community-centred behaviour change interventions. Through a sex worker-led community empowerment approach, Ashodaya Samithi reaches out to the boyfriends and husbands of sex workers through service provision, information and group discussions. Evaluations of programmes run through Ashodaya Samithi indicate that resolving incidents of violence through community empowerment and crisis response systems may reduce violence and improve HIV outcomes. Sisters, a transgender-focused, community-based initiative in Pattaya, **Thailand**, offers another example of an effective community-level behavioural change intervention that has helped to reduce the risk of HIV transmission and increase uptake of HIV and SRHR services.

Source: WHO, UNAIDS (2013), *16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool* (Geneva); Pawa, D. et al. (2013), "Reducing HIV Risk among Transgender Women in Thailand: A Quasi-Experimental Evaluation of the Sisters Program, *PLoS One* 8: e77113; Berry, S. et al. (2012), *"I'm Proud of My Courage to Test": Improving HIV Testing and Counseling Among Transgender People in Pattaya, Thailand* (Arlington, Virginia: AIDSTAR–One Case Study Series).

3.4 Strategy 2: Ensure integrated HIV/SRHR services reach both key populations and their intimate partners

Ensuring that integrated HIV and sexual and reproductive health and rights (SRHR) services reach both key populations and their intimate partners should be a key element of interventions to prevent intimate partner transmission. While there is evidence to show that messages about safer sex are being put into practice with casual or commercial partners, key populations and people living with HIV appear to have much more difficulty putting these messages into practice with intimate partners, especially spouses.[127] Drawing on

[127] PATH (2008), *Strengthening access to sexual and reproductive health services for people with HIV and for people at risk of HIV: Research evidence to promote integration or convergence of sexual and reproductive health services into HIV programmes in India* (New Delhi).

IMPORTANT REFERENCE DOCUMENTS AND RESOURCES FOR COUNTRIES:

The report *HIV/SRHR Integration for Key Populations: A review of experiences and lessons learned in India and globally*, by the India HIV/AIDS Alliance, is a valuable resource for practical examples of HIV/SRHR integration in concentrated epidemics. The publication offers examples of integrated programmes that can prevent intimate partner transmission by building on 'what's there', rather than starting from scratch. It highlights efforts to integrate selected services that are priorities for key populations, providing examples of how components to address the HIV/SRHR needs of their intimate partners may also be addressed within these interventions. The publication is accompanied by a series of Issues Briefs on HIV/SRHR integration for men who have sex with men and transgender people, sex workers, people who use drugs, and people living with HIV. The programmatic approaches described in this section draw on this important body of work.

OTHER USEFUL RESOURCES:

WHO (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (Geneva).

APN+/TREAT Asia/UNESCO/UNICEF (2013), *Lost in Transitions: Current issues faced by adolescents living with HIV in Asia Pacific* (Bangkok).

APN+ (2012), *Positive and Pregnant: How Dare You?* (Bangkok).

programmatic examples from the region, the following section puts forward two approaches to enhance the supply and demand side of integrated HIV/SRHR services for key populations and their intimate partners.

How HIV/SRHR integration can help prevent intimate partner transmission of HIV

Evidence from the region shows that adult and adolescent key populations and people living with HIV have significant unmet SRHR needs, which in turn influences the risk of HIV transmission within their intimate partner relationships.[128] For many adult and adolescent females living with HIV and/or from key populations, their main concerns often are not just about HIV and STIs but also other reproductive health issues, such as family planning and access to safe abortion and post-abortion care. Yet HIV prevention efforts among both men and women from key populations can be narrowly focused on access to HIV prevention commodities (e.g. condoms) and the diagnosis and treatment of STIs, missing a critical opportunity to address their SRHR needs. Often, these programmes do not directly address considerations for using condoms as a family planning method (e.g. emphasizing consistent use with intimate partners), discuss the importance of dual method use, offer other more reliable contraceptive method options, or provide emergency contraception – all of which are strategies relevant for the prevention of intimate partner transmission.[129]

Addressing the SRHR needs of key populations and people living with HIV can help overcome these challenges and, in doing so, can support efforts to reduce sexual transmission of HIV and prevent intimate partner transmission. It also offers an important entry point for reaching and increasing access to HIV and SRHR information and services for the intimate partners of these populations. However, significant questions and uncertainties remain about what such programming means in practice. This is particularly the case within the context of a concentrated HIV epidemic, where still little is known about what integration should look like (especially for groups such as sex workers, transgender people, men and women who inject drugs, and men who have sex with men) and what practical opportunities and challenges it involves.[130]

Use of high-quality and systematic referrals to ensure a strong 'chain' of HIV/SRHR integrated services

Evidence-based application: Integrated HIV/SRHR services can be provided under the same roof or employ a streamlined referral system to ensure that clients' HIV and SRHR needs are met. Evidence indicates that the success of many integrated HIV and SRHR services rests on the quality and effectiveness of these referral

[128] APN+ et al, *Lost in Transitions; APN+, Positive and Pregnant: How Dare You?;* Petruney et al., "Meeting the Contraceptive Needs of Key Populations."

[129] Petruney et al., Meeting the Contraceptive Needs of Key Populations.

[130] India HIV/AIDS Alliance (2012), *HIV/SRHR Integration for Key Populations: A review of experiences and lessons learned in India and globally* (New Delhi).

systems.[131] At the same time, it is important to note that there is no one single model for integrating HIV and SRHR services, and service integration does not offer a complete solution for addressing all HIV and SRHR needs. Also, programmatic guidance on HIV/SRHR integration rarely includes strategies tailored to a concentrated HIV epidemic. The evidence base for best practices for meeting the SRHR needs of key populations in Asia, those living with HIV, and their intimate partners who may be at higher risk for intimate partner transmission also remains limited.[132]

Despite these challenges, regional reviews indicate that effective referral systems can ensure stronger linkages between HIV and SRHR services in Asia's concentrated epidemics and increase service outreach to key populations, to their intimate partners, and to those living with HIV.[133] For instance, while HIV clinics serve those with HIV-specific demands, SRHR facilities see a greater number of people and a larger cross-section of the population. Where an intimate partner is unaware of their partner's risk behaviour or HIV status, SRHR centres offer a key entry point for integrating voluntary confidential counselling and testing with STI and family planning/SRHR services. Efforts to ensure a strong 'chain' of HIV/SRHR integrated services has also been shown to broaden the skills and knowledge of health care workers and reduce the likelihood of stigma and discrimination towards key populations and people living with HIV, which often prevents them from seeking SRHR and/or HIV services and from bringing their partners in for HIV/STI testing.

Implementation considerations: Given the current focus on HIV investment and programming, creating an effective referral system needs to build on what already exists, for example, in terms of existing data, services, infrastructure, funding, types of providers, accessibility and cost.[134] If integration involves referrals, it is important to ensure the quality, confidentiality, and 'key population-friendliness' of such services. Due to the narrow focus of STI and HIV services, the providers staffing these programmes may not have the required training or capacity to appropriately address the SRHR needs of their clients. Likewise, even though SRHR/family planning services may be geographically available through mainstream health facilities, adult and adolescent males and females living with HIV and/or from key populations may be reluctant to access them due to provider biases and concerns about service quality and confidentiality.[135] This reinforces the importance of creating supportive health care settings and eliminating stigma, discrimination, and human rights violations within these sites.

Programmatic initiatives from the region show that training and sensitizing health care workers on the specific needs, vulnerabilities and rights of key populations and people living with HIV can strengthen the quality and effectiveness of referral systems. It can also ensure that health care workers in family planning clinics and HIV/SRHR sites uphold human rights and the principles of Positive Health, Dignity, and Prevention in their dealings with clients.[136] A gender equality and rights-based approach also requires that women from key populations and women living with HIV should enjoy the same reproductive health rights as other women and have access to family planning and other SRHR services. Evidence indicates that appropriate and confidential referrals, if and when requested by adolescent key populations or adolescents living with HIV, can be an important entry point for providing linkages to support through other services and sectors.[137] A rights-based approach also requires that referral to SRHR services, including contraceptive information and services, be provided for adolescents without mandatory parental and guardian authorization/notification.

Creating demand for HIV/SRHR integrated services

Evidence-based application: A global review identified low demand for HIV/SRHR integrated services, stigma and discrimination related to HIV and key populations, and lack of gender equality and rights-based

131 Ibid.

132 Petruney et al., "Meeting the Contraceptive Needs of Key Populations."

133 India HIV/AIDS Alliance, *HIV/SRHR Integration for Key Populations; PATH (2012), Integration of services for HIV/AIDS and sexual and reproductive health: Pilot projects in India have paved the way for wider use of effective models, strategies, and tools* (New Delhi).

134 Ibid.

135 Petruney et al., "Meeting the Contraceptive Needs of Key Populations."

136 PATH, *Integration of services for HIV/AIDS and sexual and reproductive health; UNDP, A report on addressing the SRH needs of MSM*.

137 WHO, *Consolidated guidelines*.

approaches to service delivery as key challenges in HIV/SRHR integration.[138] While research shows that the demand for integrated services among key populations and people living with HIV is low, evidence from the region indicates that the need is high.[139] This same body of research also indicates that community mobilization is an important strategy for generating demand and improving the uptake and quality of linked services.[140] It is particularly effective in increasing uptake among hard-to-reach key population groups and their intimate partners not currently served by SRHR providers, especially sex workers, people who use drugs and men who have sex with men.

Increasingly, peer education is seen as an effective means of mobilizing underserved communities and generating demand for integrated HIV/SRHR services.[141] By training outreach workers in interpersonal communication methods, peer education can create awareness of, and mobilize demand for, SRHR services among key populations, people living with HIV, and their intimate partners. Other community-based initiatives to increase demand for integrated services include organizing face-to-face meetings between and among providers, clients, and their intimate partners and/or families. Such consultations are reported to help reduce stigma and discrimination faced by key populations, people living with HIV, and their intimate partners; increase awareness and understanding of their needs and rights among health care workers; and identify ways to improve service delivery and strengthen referral systems at the community level.[142]

Implementation considerations: Addressing how key populations' different types and levels of vulnerability interrelate – including within the context of their intimate partner relationships – is vital to increasing demand for integrated services. This requires approaches that respond to the significant diversity among sex workers, people who use drugs, men who have sex with men, transgender people and those living with HIV, and that take into consideration their specific SRHR desires and needs. For instance, the issues facing adolescent men and women living with HIV as they embark on new intimate partner relationships (such as repeated disclosure and potential sexual rejection because of HIV status) would be different from the issues facing a serodiscordant couple with known status who have made the decision to conceive.[143] Addressing the SRHR needs of adult and adolescent key populations would mean addressing issues as diverse as the sexual health priorities of men who have sex with men, the complex interactions between drug use, harm reduction, HIV and SRHR, emergency post-exposure prophylaxis and contraception for sex workers in cases of rape and sexual assault, information on the interaction between hormones and ART for transgender individuals, negotiation in sexual relationships, and access to family planning services for adolescents.

As well as generating demand and increasing uptake of integrated HIV/SRHR services, addressing these diverse demands can also address the specific risks and vulnerabilities that influence the risk of intimate partner transmission among different populations. While it is essential that integration be undertaken on the basis of evidence and adapted to local contexts, conditions and particular communities, efforts to generate demand for services must always protect and promote gender equality and human rights. This means ensuring that key populations, people living with HIV, and their intimate partners are not denied access to HIV or SRHR services based on gender, age, ethnicity, sexual orientation or marital status. A rights-based

[138] These findings were based on a global review of over 160 resources focusing on HIV/SRHR integration for key populations. The objective of the review was to assess how HIV/SRHR integration can not only improve the efficiency of programmes but truly serve the needs of key populations. The review analysed successful approaches and lessons learned to inform future programme development, implementation and evaluation. Source: Grote et al. (2012), *Reaching Key Populations in HIV/SRH Integration: Recommendations from a global intervention review to identify strategies to increase the responsiveness and relevance of integrated programming to the sexual and reproductive health and rights and needs of high-risk groups, including sex workers, MSM, transgenders, IDUs and PLHIV* (New Delhi: India HIV/AIDS Alliance).

[139] For example, although not extensively documented nor uniformly calculated, existing data reveals female sex workers in Asia have a higher than average unmet need for family planning compared to the general population. High rates of unintended pregnancies have also been documented among key populations in Asia. Abortion is legal in many Asian countries, and its common use among key populations in the region provides further evidence that many experience unintended pregnancies and have an unmet need for reliable contraception. Source: Petruney et al., "Meeting the Contraceptive Needs of Key Populations."

[140] Cited in Stop AIDS Alliance (2012), *Intensify linkages between HIV and sexual and reproductive health and rights for maximum impact: Stop AIDS Alliance policy position*.

[141] India HIV/AIDS Alliance, *HIV/SRHR Integration for Key Populations*.

[142] UNDP, *A report on addressing the SRH needs of MSM;* key informant interviews with representatives of national networks of women living with HIV in Cambodia and Indonesia (conducted July 2014).

[143] UNAIDS (2010), 26th Meeting of the UNAIDS Programme Coordinating Board. Geneva, Switzerland. 22–24 June 2010, *Thematic Segment: Sexual and Reproductive (SRH) services with HIV interventions in practice. Background Paper* (Geneva).

EXPERIENCES FROM THE REGION

Link Up is an ambitious three-year project (2013–2015), funded by the Government of the Netherlands and implemented by a group of NGO partners, to improve the SRHR of young key populations aged 10–24 in five countries, including **Bangladesh** and **Myanmar**. Link Up aims to increase demand and uptake of integrated HIV and SRHR programmes and quality services, increase the capacity of service providers, and ensure that young people are at the centre of programme planning and implementation. Through peer education and referrals, Link Up is reaching young key populations through existing community networks and peer-to-peer mobilization and is creating demand for SRHR and HIV services. Peer educators, who themselves represent young key population groups, are trained to provide SRHR and HIV education and counselling within their communities and refer their peers to public or private integrated SRHR and HIV services. In **Bangladesh**, HIV/AIDS and STD Alliance Bangladesh (HASAB) is mobilizing young key populations to reach out to their peers with integrated SRHR and HIV information, education and communications materials, including the use of hotlines and social media. Street dwellers in Bangladesh are often children particularly vulnerable to HIV. Peer education sessions are held within the railway grounds at Dhaka's largest railway station. The sessions focus on human rights, SRHR, gender, safer sex, HIV and STI prevention, and drug use. If participants require a service or would like to find out more about any health issue, they are referred to Marie Stopes Bangladesh mobile clinical services.

Source: International HIV/AIDS Alliance (2014), Link Up Project Overview: Better Sexual and Reproductive Health and Rights for Young People Most Affected by HIV (Brighton, UK).

approach also requires that policies, programmes and services proactively address stigma and discrimination as a fundamental barrier to increasing demand and access to integrated services. This includes respecting every individual's right to health, confidentiality and non-discrimination, even when reaching out with information and services to their intimate partners.

3.5 Strategy 3: Use new, proven biomedical interventions such as antiretroviral-related prevention to prevent intimate partner transmission of HIV

ARV-related prevention is a proven strategy for preventing HIV transmission and a key health-sector intervention for prevention of intimate partner transmission in particular. In Asia's concentrated epidemics, three key components of ARV-related prevention have the potential to reduce HIV transmission in intimate partner relationships: these are pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and early initiation of ART.

Several countries in the region, including **Cambodia**, **China**, **Thailand** and **Viet Nam**, are at the forefront of the implementation of ARV-related prevention, particularly in relation to preventing transmission between serodiscordant couples. **China**, for instance, has already implemented a national policy to offer treatment, irrespective of CD4 count, for people living with HIV who have a serodiscordant regular sexual partner. At the same time, early experiences of implementing ARV-related prevention demonstrate a critical need for rights-based approaches. The experience of **Viet Nam** has shown that ARV-related prevention can only work as a strategy if it is implemented in a way that fosters human rights protection, reduces stigma and discrimination, and encourages the engagement of people living with HIV, key populations and their intimate partners.[144] These and other findings suggest that ARV-related prevention is unlikely to be sufficient to reduce levels of intimate partner transmission unless combined with other prevention strategies that are anchored in a rights-based approach.[145]

[144] Kato et al. (2013), "The Potential Impact of Expanding Antiretroviral Therapy and Combination Prevention in Vietnam: Towards Elimination of HIV Transmission," *Journal of Acquired Immune Deficiency Syndrome* 62.5; Milloy et al. (2012), "Barriers to HIV treatment among people who use injection drugs: Implications for 'treatment as prevention'," Current Opinion in HIV and AIDS 7: 332–338.

[145] Jia et al. (2013), "Antiretroviral therapy to prevent HIV transmission in serodiscordant couples in China (2003–2011): A national observational cohort study," The Lancet 382.9899, 5 Oct 2013: 115–203; Wang et al. (2013), "Heterosexual transmission of HIV and related risk factors among serodiscordant couples in Henan province, China" *Chinese Medical Journal* 126.19.

IMPORTANT REFERENCE DOCUMENTS AND RESOURCES FOR COUNTRIES:

WHO (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (Geneva).

WHO (2014), *March 2014 supplement to the 2013 consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* (Geneva).

WHO (2013), *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* (Geneva).

WHO (2012), *Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV* (Geneva).

This section draws on the above guidance from the World Health Organization, with particular reference to recommendations on ARV-related prevention contained in WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (2014).

Use of pre-exposure prophylaxis (PrEP) to prevent intimate partner transmission of HIV

Evidence-based application: Studies have demonstrated the effectiveness of PrEP in reducing HIV transmission among serodiscordant heterosexual couples, men who have sex with men, transgender women, high-risk heterosexual couples and people who inject drugs.[146] WHO recommends that where serodiscordant couples can be identified who need additional choices for HIV prevention, daily oral PrEP may be considered as an additional intervention for the uninfected partner. The recommendation extends to members of key populations who are in serodiscordant relationships. As of 2014, PrEP is now recommended by WHO as an additional HIV prevention choice for all MSM, not just those in a serodiscordant couple, as part of a comprehensive HIV prevention package.[147] Evidence of the efficacy of PrEP for preventing sexual transmission of HIV among MSM – including within their intimate partner relationships – is still required, and until these results are published, existing prevention interventions such as comprehensive condom and lubricant programming and regular testing remain critical.

Implementation considerations: Although definitive guidance on how best to deliver daily oral PrEP has not been published, countries can undertake demonstration projects to ascertain the most appropriate user groups and the best delivery approaches. **India**, **China** and **Viet Nam** are already planning PrEP demonstration projects with male and female key populations and/or serodiscordant couples. In **Thailand**, an earlier demonstration project with people who inject drugs found that PrEP can reduce HIV infections associated with sexual transmission among drug users as well as transmission associated with sharing injecting equipment.[148]

In the introduction of PrEP, WHO guidelines clearly state that it is best offered as one component of a comprehensive set of HIV prevention interventions, including unfettered availability of condoms and lubricants, routine HIV testing, risk-reduction counselling, and adherence coaching. WHO also recommends that policymakers and programmers should not be prescriptive in the definition of 'serodiscordant couples' who can benefit from HIV interventions, including PrEP. This reinforces why human rights standards and principles must provide a framework for the provision of PrEP. For example, a rights-based PreP delivery system would ensure providers do not discriminate based on marital status or sexual orientation (i.e. making PrEP available only to heterosexual married and/or cohabiting couples in a serodiscordant relationship). A rights-based approach would also engage communities and providers to ensure that issues of criminalization, stigma and discrimination, and violence are taken into account when planning and implementing the delivery of PrEP.

[146] Studies cited in WHO, *Consolidated guidelines*.

[147] Despite current prevention efforts, continuing high rates of HIV incidence are being reported among men who have sex with men in Asia's concentrated epidemics. This suggests that additional prevention options such as PrEP could be important, especially to reduce and prevent HIV transmission in the sexual relationships (including intimate partner relationships) of this population group. Source: WHO, *Consolidated guidelines*.

[148] Choopanya, K. et al. (2013), "Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir Study): A randomised, double-blind, placebo-controlled phase 3 trial," *The Lancet* 381.9883, 15 June 2013: 2,083–209.

Use of post-exposure prophylaxis (PEP) to prevent intimate partner transmission of HIV

Evidence-based application: PEP is currently the only way to reduce the risk of HIV infection in an individual who has been already exposed to HIV. This includes individuals who may have been exposed within the context of their intimate partner relationships, whether as a result of consensual sex, forced sex or sharing of injection equipment. According to current WHO guidelines, the recommended duration of PEP is 28 days; the first dose should be taken as soon as possible and within 72 hours after exposure.[149]

Implementation considerations: WHO recommends that PEP should be made available to all eligible people from key populations on a voluntary basis after possible exposure to HIV. Evidence from the region shows that key populations – especially female key populations and men who have sex with men – face disproportionate levels of sexual violence, including from their intimate partners.[150] As a means of preventing intimate partner transmission, access to PEP is particularly important for members of key population communities who have been sexually assaulted, whether within the context of their intimate partner relationship or in sexual encounters outside the relationship.

IMPORTANT REFERENCE DOCUMENTS AND RESOURCES FOR COUNTRIES:

WHO (2013), *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (Geneva).

As part of broader efforts to integrate gender-based violence and HIV at the policy and service delivery levels, policymakers can develop and issue national clinical and policy guidelines responding to sexual violence (including intimate partner violence), where these do not already exist. This includes protocols for PEP and emergency contraception in cases of sexual assault. HIV PEP policies should be grounded in human rights; for example, provisions should be included to ensure that access to PEP and emergency contraception is free for all survivors of violence, irrespective of gender, age, ethnicity, sexual orientation or marital status.[151] WHO advises that HIV risk assessment and counselling specific to HIV and PEP should be included as part of this intervention. Counselling and other adherence support measures are particularly important given that completion rates for PEP are low (despite its short duration). According to WHO guidelines, ongoing comprehensive services should also be available for people following PEP, including treatment and care for people who seroconvert.

Early initiation of ART regardless of CD4 count to prevent intimate partner transmission of HIV

Evidence-based application: There is increasing evidence of the potential of ART to reduce HIV transmission by lowering viral load. The benefit of ART in preventing new HIV infections within intimate partner relationships has been confirmed by the HIV Prevention Trials Network (HPTN) 052 study – a two-arm, multi-site (nine countries, including two from Asia) randomized trial on the effectiveness of treatment strategies among serodiscordant couples, which found that early initiation of ART results in a 96 percent reduction in sexual transmission. The evidence supports early initiation of ART in individuals, irrespective of CD4 count, for prevention of HIV transmission. In the context of intimate partner transmission, current WHO ARV guidelines recommend initiation of ART regardless of CD4 count for the HIV-positive partner in serodiscordant couples. The rationale for this is to scale-up access to ART as well as to decrease risk of HIV transmission, including intimate partner transmission.

Implementation considerations: HIV testing is crucial to preventing HIV transmission in intimate partner relationships. Yet knowing one's HIV status is often not enough. Even where treatment is free, countries in the region have reported large gaps between the numbers of people who test positive and those who start – and

[149] WHO post-exposure prophylaxis (PEP) guidelines will be updated in late 2014 for all populations. At the time of writing, these guidelines were not available. The recommendations made here are based on WHO, *Consolidated guidelines*.

[150] Evidence cited in Chapter 2 of this report.

[151] In the context of HIV PEP, key human rights obligations are to ensure the right to the highest attainable standard of health, to protect against violence and its consequences, and to protect rights to privacy and bodily integrity.

EXPERIENCES FROM THE REGION

A number of countries in Asia have taken important preparatory steps towards earlier initiation of ART as a strategy to reduce and prevent intimate partner transmission of HIV. At the policy level, **China** is undertaking a rapid roll-out of its national policy to provide ART for people living with HIV who have a serodiscordant regular partner, irrespective of CD4 count. In **Indonesia**, national and subnational policies are supporting the strategic use of ARVs (a 'test-and-treat' approach) for key populations in selected provinces as a strategy to prevent sexual transmission of HIV, including within intimate partner relationships. **Thailand** has done important work on the development of tools and processes for couples counselling, which could potentially support early ART initiation for the HIV-positive partner in a serodiscordant relationship.

Source: WHO (2012), WHO-NIH Informal Consultation on Antiretroviral Treatment as HIV Prevention: Implementation Science in Asia, 26–28 March 2012, Siem Reap, Cambodia (Meeting Report, Executive Summary); and http://www.unaids.org/en/resources/presscentre/featurestories/2014/may/20140512indonesia.

are able to maintain – treatment.[152] In order to prevent intimate partner transmission, much more needs to be done to bridge the gap between testing and early initiation of ART, and to keep people on treatment. These ongoing challenges are a reminder why WHO recommends that ART should be used in combination with other biomedical interventions that reduce HIV risk practices and/or reduce the probability of HIV transmission per contact event, including male and female condoms, needle and syringe programmes, opioid substitution therapy with methadone or buprenorphine, and voluntary medical male circumcision. At the same time, prevention of intimate partner transmission and the use of ART for either prevention or treatment depend upon the ability of key populations and HIV-positive individuals to seek out services and then use those services over the course of a lifetime. Studies have shown that social and structural factors place significant barriers to optimal ART use among these groups, undermining efforts to promote early initiation of ART.[153] This highlights once again the importance of creating a more enabling environment for ARV-related prevention that respects human rights and engages local communities of key populations and people living with HIV. As part of this effort, ARV-related prevention approaches must be underpinned by the principles of Positive Health, Dignity and Prevention. Accordingly, national protocols on ARV-related prevention should uphold principles related to the dignity and agency of people living with HIV to participate in the design and implementation of programmes and to make informed decisions about their health and lives.

3.6 Strategy 4: Increase the involvement of male intimate partners in integrated ANC/MCH and PMTCT services

Adopting a family-centred approach to integrated ANC/MCH and PMTCT services can be an effective strategy to reduce the risk of intimate partner transmission and mother-to-child transmission of HIV. Within ANC settings, the poor disclosure of HIV test results, low level of male partner engagement, and lack of uptake and use of couples HIV testing and counselling (CHTC), as well as the overall stretched capacity of MCH programmes, still pose many challenges for prevention of intimate partner transmission, especially for those in serodiscordant relationships.[154] Innovative programming in the region has identified two important components of a more family-centred approach for preventing intimate partner transmission: improved access and quality of ANC/ MCH and PMTCT services for adult and adolescent females from key populations; and increased male partner involvement in integrated ANC/MCH and PMTCT services.

[152] Barr et al. (2011), "Articulating a rights-based approach to HIV treatment and prevention interventions," *Current HIV Research* 9: 396–404.

[153] Kato et al., "The Potential Impact of Expanding Antiretroviral Therapy and Combination Prevention in Vietnam."; Milloy et al., "Barriers to HIV treatment among people who use injection drugs."

[154] Asia Pacific United Nations Prevention of Parent to Child Transmission of HIV and AIDS Task Force (2013), *The 9th Meeting of the Asia-Pacific United Nations Task Force for the Prevention of Parents-to-Child Transmission*, 27–29 August 2013, Kathmandu, Nepal (Conclusions and Recommendations).

IMPORTANT REFERENCE DOCUMENTS AND RESOURCES FOR COUNTRIES:

Asia Pacific United Nations Prevention of Parent to Child Transmission of HIV and AIDS Task Force (2013), *The 9th Meeting of the Asia-Pacific United Nations Task Force for the Prevention of Parents-to-Child Transmission, 27–29 August 2013, Kathmandu, Nepal* (Conclusions and Recommendations).

Asia Pacific United Nations Prevention of Parent to Child Transmission of HIV and AIDS Task Force (2013), Elimination of New Paediatric HIV Infections and Congenital Syphilis in Asia-Pacific. An Advocacy Toolkit.

WHO (2012), *Male involvement in the prevention of mother-to-child transmission of HIV* (Geneva).

WHO (2012), *Guidance on Couples HIV Testing and Counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for public health approach* (Geneva).

Stone-Jimenez et al. (2011), *Technical Brief: Integrating Prevention of Mother-to-Child Transmission of HIV Interventions with Maternal, Newborn and Child Health Services* (Arlington, Virginia: USAID AIDSTAR-One, Task Order I.)

Improved access and quality of ANC/MCH and PMTCT services for key populations and their families

Evidence-based application: Integration of PMTCT with ANC/MCH can improve the access, quality and reach of HIV prevention services for key populations and their intimate partners, and for those in serodiscordant relationships. Countries across the region recognize that increasing uptake early in the PMTCT cascade, achieving high retention in care for HIV-positive pregnant women, and viral load suppression are critical to preventing vertical transmission of HIV.[155] Yet existing efforts to offer PMTCT services to women at higher risk of HIV infection remain insufficient, and primary prevention programmes with key populations do not always provide necessary information on intimate partner transmission and PMTCT.[156] Stronger linkages and collaboration among MCH, reproductive health, and STI and HIV programmes from the levels of national policy to service delivery can help to address these issues.

Through a range of strategic interventions, integration of PMTCT with ANC/MCH can also support a more family-centred approach to the prevention of intimate partner transmission – for example, by providing more entry points for CHTC, expanding HIV testing to families of key populations, and increasing testing rates and follow-up care for intimate partners at higher risk for HIV who may be otherwise difficult to reach. Integration

EXPERIENCES FROM THE REGION

In Mumbai, **India**, the local community-based organization, the *Humsafar Trust*, has established linkages with MCH clinics and organizations providing SRHR services primarily for women. These referral mechanisms facilitate service provision to intimate partners/wives of MSM even if the partner/spouse is unaware of the sexual identity and behaviours of their MSM partner. Training and sensitization of MCH staff has helped ensure these referral mechanisms protect the health and human rights of both the MSM client and their intimate partners. In **Pakistan**, the National AIDS Control Programme and local NGO, the *Nai Zindigi Trust*, have worked with male peer networks to increase the uptake of CHTC among men who inject drugs and their wives and children in Lahore. The initiative also offers support and strong referral linkages to ANC/MCH and PMTCT services for female partners who would otherwise be difficult to reach.

[155] Ibid. PMTCT programmes require newly pregnant women to complete a series of sequential steps, also known as the 'PMTCT cascade', that are aimed at first diagnosing and then treating HIV infection. Under ideal circumstances, in which no barriers exist to the completion of all tasks along the cascade, PMTCT has been shown to be highly effective at reducing HIV transmission to less than 2 percent at childbirth. For more information about the different steps along the PMTCT cascade, see Stringer, E. M., Chi, B. H., Chintu, N., et al. (2008), "Monitoring effectiveness of programmes to prevent mother-to-child HIV transmission in lower-income countries," *Bulletin of the World Health Organization* 86.1, Jan 2008: 57–62.

[156] Ibid.

is also improving the coverage and reach of ANC/MCH and PMTCT interventions for adult and adolescent women from key populations who have less access to PMTCT than women in the general population.[157]

Implementation considerations: Integration of PMTCT with ANC/MCH remains a complex and lengthy process with different countries in Asia at different stages of integration. According to UNICEF, while PMTCT services have, by necessity, been implemented within ANC/MCH settings, ART services have generally not. As a result, there has been a gulf within the continuum of care between ART services and ANC/MCH services. Demand-side bottlenecks also need addressing, as women – especially those from key populations – are often not well informed of what services they should receive, why these services are important, or where and when they can access them.[158] By bringing ART, PMTCT and ANC/MCH services together for fuller integration, the implementation of lifelong ART for all HIV-positive pregnant and breastfeeding women (a strategy termed by WHO and UNICEF as 'Option B+') can provide an opportunity to address these and other structural and operational bottlenecks in the PMTCT cascade.[159]

In removing these barriers and bottlenecks, governments in the region are obligated to address human rights issues in accordance with international human rights instruments that have been signed or ratified by each Member State (e.g. ICESCR, ICCPR, CEDAW, CRC and the 2011 UN Political Declaration on HIV and AIDS). As a work in progress, integration of PMTCT with ANC/MCH enables countries in the region to meet these obligations by taking a family-centred approach that supports not only the HIV and SRHR needs of key populations but those around them. The rights to choose the number and spacing of children; to have comprehensive and accurate information on health, treatment and family planning; and to have confidentiality protected should be upheld consistently in the delivery of ANC/MCH and PMTCT services. This includes enabling men and women to choose when and if to start ARV treatment and which treatment they wish to receive (if a choice of regimen is available).

A rights-based approach also requires that adult and adolescent males and females living with HIV have access to appropriate information that enables them to make their own decisions about what is best for them. As part of this, the principles of Positive Health, Dignity and Prevention should be ensured and upheld at all stages of integrated programming. A rights-based approach to integrated ANC/MCH and PMTCT services should also promote equitable access to services, especially for individuals in key affected and other marginalized populations, including adult and adolescent females. Even where information and referral services are provided, social and structural barriers – including the legal and policy environment, stigma and discrimination, and intimate partner violence – can prevent female key populations and intimate partners of men with high-risk behaviours from accessing HIV prevention services in ANC/MCH settings. For example, female drug users and sex workers may perceive HIV testing and counselling during pregnancy as a potential risk for stigmatization, discrimination, prosecution or losing custody of their children.[160] This reinforces the importance of an enabling environment to improve access and quality of ANC/MCH and PMTCT services for key populations and their families.

Increased male partner involvement in integrated ANC/MCH and PMTCT services

Evidence-based application: In Asia, data from national demographic and health surveys show that men have a clear role in decision-making about contraception, family planning and use of health services. Male involvement should be viewed as a critical element in providing family-focused services to pregnant mothers living with HIV as well as their infants and family members. It is also important in the prevention of intimate partner transmission and can help couples who are seronegative to remain so.[161] To date, different definitions of male partner involvement in ANC/MCH and PMTCT have been used in different studies, resulting in difficulties when comparing data. In addition, few interventions addressing the issues and challenges around

[157] In particular, people who inject drugs, their partners and sex workers have less access. Also, adolescent girls in general and from key populations in particular have less access to PMTCT interventions and have worse outcomes. Source: WHO, *Consolidated guidelines*.

[158] UNICEF (2012), *Option B and B+: Key considerations for countries to implement an equity-focused approach. Draft for Discussion*.

[159] Ibid. The publication provides guidance on specific actions that can be taken to address these challenges through the implementation of the Option B+ approach.

[160] WHO, *PMTCT Strategic Vision 2010–2015: Preventing Mother-to-Child Transmission of HIV to reach the UNGASS and Millennium Development Goals* (Geneva).

[161] See http://www.eptctasiapacific.org/taxonomy/term/1067.

male partner involvement in these services have been rigorously evaluated. However, there is a growing body of research to suggest that male partner involvement in ANC/MCH and PMTCT services can help to reduce levels of both intimate partner transmission and mother-to-child transmission.[162] It can also be an effective way to reach men at higher risk of HIV (such as male clients of sex workers or hidden MSM) who may not be easily reached through HIV prevention outreach. Additionally, research suggests that couples who are well informed about HIV prevention and PMTCT may be more likely to adopt low-risk behaviours and increase mutual support, regardless of the test result, helping to reduce the risk of intimate partner transmission.[163] Studies also show that women who come to ANC visits with their partners had lower rates of mother-to-child transmission compared with women with partners who were uninvolved.[164]

Implementation considerations: Partner testing is the first step in involving the male partner, regardless of the couple's HIV status. Couples HIV testing and counselling is therefore an essential component of family-centred approaches to preventing intimate partner transmission and mother-to-child transmission. However, involving partners in ANC and MCH services through couples counselling, individual counselling or other measures is often challenging and needs to be carefully thought out to ensure the effects are positive.[165] For example, one concern with CHTC, particularly in ANC settings, is partner violence. It is therefore essential that efforts to increase male involvement in integrated ANC/MCH and PMTCT services adhere to fundamental principles of human rights. Service providers in ANC/MCH settings must receive training on human rights and protection issues and be aware of all relevant support services for timely and appropriate referrals. When planning and developing HIV programmes to increase male partner involvement in ANC/MCH and PMTCT services, explicit description of human rights and gender-based violence issues and related programmatic elements must be included.

In Asia's concentrated epidemics, efforts to involve male partners in ANC/MCH and PMTCT services also need to take into account the specific risks and vulnerabilities faced by adult and adolescent key populations and how these affect their relationships, including how they communicate and negotiate safer sex with their intimate partners. For example, in couples where one or both injects drugs, CHTC may be tailored to help partners disclose injection and sexual risk outside of the relationship and to be prepared, prior to testing, to make risk assessment and reduction plans together. In instances where the sexual identities of married MSM

EXPERIENCES FROM THE REGION

In 2013, nine countries in the region had national policies relating to couples HIV testing and counselling. These policies offer counselling to couples to test together and learn their HIV status together or recommend testing for the partner of HIV-positive pregnant women. As part of efforts to support family-centred approaches to preventing intimate partner transmission and mother-to-child transmission, all of these countries include a specific indicator within the national HIV M&E framework to monitor male participation in ANC: the '*Percentage of Pregnant Women attending ANC whose male partner was tested for HIV in the last 12 months*.'

Source: The 9th Meeting of the Asia-Pacific United Nations Task Force for the Prevention of Parents-to-Child Transmission, 27–29 August 2013, Kathmandu, Nepal (Conclusions and Recommendations).

[162] Male partner involvement is sometimes classified in two categories: 'positive male partner involvement' and 'negative partner involvement'. Positive male partner involvement increases the engagement of women and men in PMTCT activities. This includes discussing HIV testing with the partner, being supportive regardless of the HIV result, participation in couples counselling, and willingness to accompany the pregnant women to ANC clinics. 'Negative male partner involvement' includes intimate partner violence, not discussing HIV testing with the partner, and even prohibiting the partner to be HIV tested. For the purposes of this section of the report, the focus is on positive male partner involvement. Source: Ditekemena et al. (2012), "Determinants of male involvement in maternal and child services in sub-Saharan Africa: A review," *Reproductive Health* 9.32.

[163] Ibid., Ditekemena et al.

[164] Aluisio, A. et al. (2011), "Male antenatal attendance and HIV testing are associated with decreased infant HIV infection and increased HIV-free survival," *Journal of Acquired Immune Deficiency Syndrome* 56.1: 76–82; Delvaux et al. (2009), "Determinants of nonadherence to a single-dose nevirapine regimen for the prevention of mother-to-child HIV transmission in Rwanda," Journal of Acquired Immune Deficiency Syndrome 50: 223–230; Kiarie et al. (2003), "Compliance with antiretroviral regimens to prevent perinatal HIV-1 transmission in Kenya," AIDS 17: 65–71.

[165] Stone-Jimenez et al. (2011), *Technical Brief: Integrating Prevention of Mother-to-Child Transmission of HIV Interventions with Maternal, Newborn and Child Health Services* (Arlington, Virginia: USAID AIDSTAR-One, Task Order I).

have not been disclosed to their wives, care needs to be taken to provide CHTC services while also maintaining confidentiality. Counsellors can also identify couples at risk of violence based on a history of abuse, help ensure safety and care for those who experience violence, and make appropriate referrals, including to peer support groups for serodiscordant couples.[166]

3.7 Strategy 5: Reform laws and policies that can hinder efforts to prevent intimate partner transmission of HIV

An enabling environment is a necessary prerequisite for key populations and people living with HIV to be able to promote and protect their own sexual health and that of their intimate partners. Without a supportive environment for prevention, each of the other high-impact strategies described in this report will have only limited effectiveness. In Asia's concentrated epidemics, three areas of legal and policy reform are of particular relevance to the prevention of intimate partner transmission. These areas relate to the criminalization of certain behaviours, the requirement of marriage or spousal consent to access HIV and SRH services, and consent policies that create age-related barriers to HIV, SRHR and other related services. Changing legislation and adopting new laws and protective policies in these three areas can make it easier for key populations and people living with HIV *as well as their intimate partners* to access health and social services and to adopt behaviours that can protect themselves and their sexual partners from HIV transmission, including intimate partner transmission.

IMPORTANT REFERENCE DOCUMENTS AND RESOURCES FOR COUNTRIES:

WHO (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (Geneva).

UNAIDS, UNFPA, UNDP, APNSW (2013), *Legal protections against HIV-related human rights violations: Experiences and lessons learned from national HIV laws in Asia and the Pacific* (Bangkok).

UNDP, WAP+, APN+, SAARCLAW (2013), *Protecting the rights of key HIV-affected women and girls in health care settings: a legal scan. Regional report* (Bangkok).

UNESCO, UNFPA, UNAIDS, UNDP, YouthLEAD (2013), *Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services* (Bangkok).

UNDP, UNFPA, UNAIDS (2012), *Sex Work and the Law in Asia and the Pacific* (Bangkok).

UNDP & APCOM (2010), *Legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific* (Bangkok).

APN+ (2012), *Positive and Pregnant: How Dare You?* (Bangkok).

Reform of laws and/or policies that criminalize the conduct of key populations and people living with HIV

Evidence-based application: Global and regional studies have found that decriminalizing behaviours such as injecting and other drug use, sex work, same-sex activity, and nonconforming gender identities are 'critical enablers' that can change a hostile environment for key populations and people living with HIV to a supportive one.[167] In recent years, most countries in the region have undertaken national reviews and consultations on legal and policy barriers to universal access to HIV services. These studies and reviews have concluded that without protective policies and decriminalization of the behaviour of key populations, barriers to essential health services will remain; many people from key populations may fear that seeking health care will expose them to adverse legal consequences. An unsupportive legal and policy environment not only makes it less likely that key populations will access HIV and SRHR services, but it can also discourage their intimate partners from accessing a range of services as well. Studies have also shown that the criminalization of HIV non-disclosure, exposure and transmission does not have beneficial public health outcomes and can exacerbate stigma against people living with HIV, with a disproportionate impact on

[166] Ibid.

[167] WHO, *Consolidated guidelines*. See also relevant publications listed in the text box on this page.

EXPERIENCES FROM THE REGION

As a result of recent policy changes in **Bangladesh** and judicial decisions in **India**, **Nepal** and **Pakistan**, these countries now legally recognize a third gender. The Ministry of Social Welfare of Bangladesh and the Supreme Courts of India, Nepal and Pakistan have chosen to address these issues by clearly communicating that all people – including transgender persons – are entitled to the fundamental rights guaranteed to them by international agreements and domestic constitutions. Legal recognition of a third gender and transgender people helps reduce stigma and discrimination, making it easier to access government and medical services and to receive the state's protection. This is a critical step towards halting HIV in the region and represents steps to implement commitments made on universal access to HIV prevention, treatment, care, and support in Economic and Social Commission of Asia and the Pacific (ESCAP) resolutions 66/10 and 67/9, as well as the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, adopted by the United Nations General Assembly in 2011.

Source: ESCAP, Social Development Division, 4 July 2014; http://www.unescapsdd.org/news/recent-judicial-rulings-and-policy-changes-create-more-enabling-legal-environment-fight-against.

women living with HIV who may be more likely to know their status as a result of antenatal HIV testing.[168] By making people living with HIV feel at even greater risk of discrimination, provisions criminalizing HIV non-disclosure, exposure and transmission can undermine self-disclosure and provider-facilitated disclosure of serostatus to intimate partners, potentially increasing the risk of intimate partner transmission within the relationship.

Implementation considerations: The Global Commission on HIV and the Law, UN agencies, human rights organizations and key population groups recommend that specific consideration should be given to these types of legal reforms as part of any revision of policies or programmes for key populations. This is supported by international human rights instruments and regional policy commitments, which underscore the need for law reform firmly grounded in human rights and the meaningful engagement of key population communities.[169] For Asian countries, this includes eliminating the practice of using possession of condoms as evidence of sex work and grounds for arrest, banning compulsory treatment for people who use and/or inject drugs, decriminalizing the use of clean needles and syringes, legalizing opioid substitution therapy for people who are opioid-dependent, and providing legal recognition for transgender people. These types of policy reform measures can help to reduce the social and structural factors (including stigma, discrimination, gender-based violence and gender inequities) that influence the risk of HIV transmission within intimate partner relationships. Such reforms can enable people from key populations to exercise their human and health rights, helping them to protect their own sexual health and that of intimate partners. For instance, these changes can help prevent intimate partner transmission by supporting better access, uptake and provision of HIV and SRHR-related services not just among key populations but also by their intimate partners. Additionally, countries can review laws that penalize health care providers for working with key populations (e.g. laws that make it illegal for outreach workers to carry condoms or distribute clean needles and syringes).

[168] Weait, M. (2011), "The Criminalisation of HIV Exposure and Transmission: A Global Review," Working Paper prepared for the Third Meeting of the Technical Advisory Group, Global Commission on HIV and the Law, 7–9 July 2011.

[169] Among others, this includes the Convention on the Elimination of all Forms of Discrimination against Women; the Convention on the Rights of the Child; and the Economic and Social Commission for Asia and the Pacific Resolution 66–10, which calls on States to "ground universal access in human rights and undertake measures to address stigma and discrimination, as well as policy and legal barriers to effective HIV responses, in particular with regard to key affected populations," and Resolution 67–9, which requires States to recall the "Human Rights Council Resolution 16/28 of 25 March 2011 on the protection of human rights in the context of HIV and AIDS."

Reform of laws and/or policies that require marriage or spousal consent to access HIV, SRHR, and other related services

Evidence-based application: Regional studies have shown that the requirement of marriage or spousal consent to access a range of HIV and SRHR-related services undermines efforts to prevent HIV transmission within intimate partner relationships.[170] Although some countries are introducing policies that encourage the reorientation of HIV and SRHR-related services to unmarried young persons, SRHR services – as well as some HIV services such as PrEP – remain strongly oriented towards the needs of married couples only. For example, some SRHR service delivery systems in the region do not cater to the needs of unmarried adolescents, and public health facilities will only provide contraceptives to married couples. In particular, the requirement of spousal consent undermines the right of women and adolescent girls to receive health services. This includes services that may help to reduce the risk of intimate partner transmission and PMTCT, such as the provision of family planning and HIV commodities. In other situations, PrEP for individuals in a serodiscordant relationship is provided mainly or exclusively to heterosexual married or cohabiting serodiscordant couples. This is despite WHO guidance that urges policymakers and health workers not to be prescriptive in the definition of couples who can benefit from interventions.[171]

> For women who are already married, it's easier to get access to contraceptives. But if we request access as a young woman, it's still hard, even to obtain condoms to protect us from STI, HIV, and unplanned pregnancy. But for adults, it's much easier to access.
>
> **YOUNG UNMARRIED WOMAN FROM INDONESIA, CITED IN UNESCO, UNFPA, UNAIDS, UNDP, YOUTHLEAD (2013).**

Implementation considerations: In the provision of HIV and SRHR services and commodities (including male and female condoms, lubricants and access to safe abortion services), a human rights and gender equality-based approach requires abolishing legal or policy requirements that discriminate against women and young people on the grounds of marital status. This is in accordance with international human rights agreements that countries in Asia are signatory to, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). As part of HIV prevention efforts, WHO supports this position with its recommendation that third-party authorization requirements be eliminated, including male and spousal authorization for women obtaining contraceptives and related information and services.[172]

Review of consent policies to remove age-related barriers to HIV, SRHR and other related services

Evidence-based application: Studies have shown that many countries in the region place age restrictions on information (including education and guidance on sexual health, contraception and safe abortion), services (such as HIV or STI testing and methadone programmes), or commodities (such as contraceptives, condoms and lubricants).[173] Regional research with young key populations and adolescents living with HIV have found that such laws and policies can be barriers to or can discourage these populations from seeking information and services that could help them to protect their own sexual health and that of their sexual partners.[174] This can further increase HIV risk and vulnerability within their intimate sexual relationships, which are often characterized by gender power imbalances and limited negotiating power. These restrictions can also create complex dilemmas for providers who strive to act in the best interest of their clients, but who may have concerns about their own legal liability as well as for the safety of their young clients.[175]

[170] APN+, Positive and Pregnant: How Dare You?; UNESCO, UNFPA, UNAIDS, UNDP, YouthLEAD (2013), *Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services* (Bangkok); UNDP, WAP+, APN+, SAARCLAW, *Protecting the rights of key HIV-affected women and girls in health care settings;* Sciortino, R. (2012), *Achieving Contraceptive Security and Meeting Reproductive Health Needs in South East Asia* (Bangkok: Asia Pacific Alliance for Sexual and Reproductive Health and Rights).

[171] WHO (2012), *Guidance on Couples HIV Testing and Counselling*.

[172] WHO, *Consolidated guidelines*.

[173] Abdullah, R. (2009), *Increasing Access to the Reproductive Right to Contraceptive Information and Services, SRHR Education for Youth and Legal Abortion* (Kuala Lumpur: ARROW); UNESCO et al., *Young people and the law in Asia and the Pacific;* APN+ et al., Lost in Transitions.

[174] Ibid.

[175] WHO, *Consolidated guidelines*.

Implementation considerations: A human rights and gender equality-based approach to preventing intimate partner transmission among young key populations and adolescents living with HIV is essential. This includes upholding the principles of CEDAW, CRC and Positive Health, Dignity and Prevention. Because the definition of an intimate partner (and the patterns of unsafe sex associated with such partnerships) are often different for youth compared to the adult population, efforts to prevent intimate partner transmission among young key populations and adolescents living with HIV need to be sensitive to their specific needs and vulnerabilities, and to how these may vary based on ethnicity, gender, and sexual orientation. In following these rights-based approaches, WHO good practice recommendations encourage countries in the region to examine their current consent policies and consider revising them to reduce age-related barriers to HIV services and to empower providers to act in the best interest of the adolescent.[176] These guidelines emphasize that lowering the age of consent and considering exceptions to a standard age of consent policy (such as mature minors) can create a more enabling environment for HIV prevention, especially for young and adolescent key populations, including those living with HIV. It is recommended that SRH services, including contraceptives, be provided for adolescents without mandatory parental or guardian authorization and notification. The same WHO guidelines also encourage countries to reduce age-related barriers to access and uptake of HIV testing and counselling and to linkages to prevention, treatment and care following testing. To this end, WHO recommends that young people should be able to obtain HIV testing and counselling without requiring the consent or presence of parents or guardians.

[176] Ibid.

4 Recommendations

BOX 5 THE REGIONAL POLICY CONTEXT: EXISTING COMMITMENTS TO HEALTH AND HUMAN RIGHTS

Asian and Pacific Ministerial Declaration on Population and Development (2013): A regional declaration reaffirming the linkages among HIV, sexual and reproductive health and rights, and gender-based violence. Underscoring the importance of non-discrimination, ending gender-based violence, and of universal sexual and reproductive health, services and rights, the declaration commits countries in the region to address legal and policy barriers that impede access to HIV services, and to prohibit human rights violations in health care settings.

South Asian Association for Regional Cooperation in Law (SAARCLAW) Declaration on Ensuring Access to Justice in the Enforcement of Human Rights (2013): A commitment by SAARC policy makers to actively support the development and enforcement of legal protections for women and girls living with HIV and for key populations in countries in the SAARC region, including protection from rights violations in health care and other institutional settings.

ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths (2011): A commitment by ASEAN Member States to promote the health, dignity and human rights of people living with HIV and key populations by promoting legal, political and social environments that enable HIV responses. ASEAN Member States pledge to eliminate gender equalities and gender-based violence by protecting and promoting the rights of women and adolescent girls to protect themselves from HIV, and to have access to health services, including sexual and reproductive health. The Declaration also notes the specific vulnerabilities of intimate partners of key populations and the need for interventions to address intimate partner transmission of HIV.

ESCAP Resolutions 67/9 (2011) and 66/10 (2010): These are regional commitments that call upon members and associated members to address stigma and discrimination, as well as policy and legal barriers, to effective HIV responses. This includes initiating a review of national laws, policies and practices with a view to eliminate all forms of discrimination against people living with HIV or at risk of infection, particularly key populations.

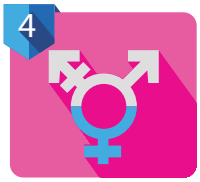
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and Convention on the Rights of the Child (CRC): All ASEAN and SAARC Member States have ratified or acceded to CEDAW and the CRC.

4.1 Recommendations to policymakers

Provide the policy mandate and steer the national programme towards systems to strengthen data collection, triangulation and synthesis related to intimate partner transmission of HIV. These efforts can be supported by adopting a consistent national definition of intimate partner relationships which is integrated in data collection tools, by strengthening age and gender disaggregation of data on key populations, and through operational research on sexual risk behaviour and sexual decision-making among key populations and serodiscordant couples. Funding to support this type of operations research and strengthened data collection can be included as part of funding applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Include strategies to prevent intimate partner transmission of HIV in national HIV plans and funding applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria. This includes greater allocation of resources in sectoral budgets and Global Fund programmes to interventions that reach out to the intimate partners of key populations and people living with HIV.

Harmonize national sexual and reproductive health (SRH) and HIV/sexually transmitted infection strategies and related health institutions in order to expand outreach and coverage of services to key populations, people living with HIV, and their intimate partners. Special attention should be given to the effective provision of linked and integrated services for key populations, people living with HIV, and serodiscordant couples that are appropriate to age and gender.



Use national gender equality policies and plans of action to address the factors that increase HIV risk and vulnerability in intimate partner relationships. National gender equality action plans and policies can be entry points for identifying specific measures and resources to eliminate gender inequalities and gender-based abuse and violence experienced by male, female and transgender key populations and men, women, girls and boys living with HIV. In particular, gender-based violence laws should ensure that the definition of rape includes marital rape and is gender-neutral (i.e. includes protection for men and boys and transgendered persons who may also be victims of sexual assault). Where these do not already exist, policymakers should also develop and issue national clinical and policy guidelines responding to intimate partner violence and sexual violence, including protocols for post-exposure prophylaxis (PEP) and emergency contraception in cases of sexual assault. Provisions should be included to ensure that access to PEP and emergency contraception is free for all survivors of violence, irrespective of gender, age, ethnicity, sexual orientation or marital status.

Review and reform laws and policies that hinder efforts to reach the intimate partners of key populations and people living with HIV with information and services. This includes reforming laws that criminalize the conduct of key populations or people living with HIV and that require marriage or spousal consent to access HIV, SRHR and related services. It also encompasses the review and revision of consent policies to reduce age-related barriers to HIV and SRHR services and to empower providers to act in the best interest of adolescents. Special attention should be given to recommended legal and policy reforms that can eliminate stigma, discrimination and violence towards key populations and people living with HIV: for example, decriminalization of behaviours such as injecting and other drug use, sex work, same-sex activity and nonconforming gender identities, as well as decriminalization of HIV transmission and exposure. As part of these efforts, train law enforcement officials and health and social care providers to recognize and uphold the human rights of key populations and people living with HIV, and hold them accountable if they violate these rights, including by perpetrating violence.*

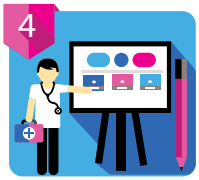
* indicates recommendations based on or taken from WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations (2014).

4.2 Recommendations to programmers and practitioners

Strengthen data collection and strategic information as it relates to HIV risk and vulnerability in the context of intimate partner relationships, and use this to develop evidence-based interventions to prevent intimate partner transmission of HIV. This is relevant for those developing and implementing programmes at national, sub-national and community levels. It may require additional data collection, further analysis of pre-existing data, or the commissioning of operational research. It can also include the triangulation of information from research and programmes with adult and adolescent males and females from key populations as well as those living with HIV (identifying what works – and what doesn't – in the specific context of preventing intimate partner transmission of HIV). This recommendation is also relevant to policymakers.

Scale-up and expand effective HIV prevention strategies with key populations to include components to reach their intimate partners with information, referrals and services. This includes greater attention and allocation of resources to interventions that promote male responsibility for HIV prevention, that empower women from key populations to protect themselves and their sexual partners, and that extend service outreach to intimate partners.

Create demand as well as flexible delivery and supply for HIV/SRHR integrated services among adult and adolescent key populations and serodiscordant couples. Efforts should start with the integration of services (e.g. access to contraception, safe abortion and family planning) that are priorities for the community and relatively easy to implement, building on existing HIV and SRHR programming.



Train and sensitize health care workers to ensure that they have the skills and understanding to provide age and gender-appropriate services to key populations and people living with HIV as well as to their intimate partners, based on all persons' right to health, confidentiality and non-discrimination.*

Working with communities and service providers to identify and overcome barriers to access and utilization of ANC/MCH and PMTCT services among women from key populations and their intimate partners. Special effort and initiatives are needed to optimize access to care and adherence support for HIV-positive men, women and adolescents from key populations and to support effective linkages to long-term treatment. This is especially true for HIV-positive women during breastfeeding, a period when follow-up is often poor.*

Expand access to couples HIV testing and counselling and antiretroviral treatment for women and their intimate partners in ANC and MCH clinics.

* indicates recommendations based on or taken from WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations (2014).

Scale-up initiatives that increase male involvement in HIV testing during ANC and improve male participation in couples HIV testing and counselling.

Implement biomedical interventions, including ARV-related prevention, to prevent HIV transmission from HIV-positive individuals to their intimate partners. Countries should refer to the most recent technical guidance from the World Health Organization. At the time of publication, this includes recommendations on ARV-related prevention contained in WHO's Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (August 2014). Such approaches must be underpinned by the principles of Positive Health, Dignity and Prevention. Accordingly, national protocols on ARV-related prevention should uphold principles related to the dignity and agency of people living with HIV to participate in the design and implementation of programmes and to make informed decisions about their health and lives.

REFERENCES

Abdullah, R. (2009), *Increasing Access to the Reproductive Right to Contraceptive Information and Services, SRHR Education for Youth and Legal Abortion* (Kuala Lumpur: Asian-Pacific Resource and Research Centre for Women).

Aluisio, A. et al. (2011), "Male antenatal attendance and HIV testing are associated with decreased infant HIV infection and increased HIV-free survival," *Journal of Acquired Immune Deficiency Syndrome* 56.1.

Apoorva et al. (2013), "Risky Behaviors among HIV-Positive Female Sex Workers in Northern Karnataka, India, *AIDS Research and Treatment*, article ID 878151.

Aryal et al., (2013), "Vulnerability to unsafe sex and HIV infection among wives of migrant workers in far western Nepal," *Journal of Chitwan Medical College* 3.3.

Asia Pacific Network of People Living with HIV/AIDS (2012), *Positive and Pregnant: How Dare You?* (Bangkok).

Asia Pacific Network of People Living with HIV/AIDS, TREAT Asia, UNESCO, UNICEF (2013), *Lost in Transitions: Current issues faced by adolescents living with HIV in Asia Pacific* (Bangkok).

Asia Pacific Interagency Task Team on Women, Girls, Gender Equality and HIV (2012), *Report of the roundtable on data synthesis exercises to better understand the number of women at risk of HIV through intimate partner transmission*, 18 May 2012 (Bangkok).

Asia Pacific Transgender Network and Asia Pacific Coalition on Male Sexual Health (2013), *Policy Brief: Overlooked, Ignored, Forgotten: HIV and Basic Rights of Transgender People in Asia and the Pacific* (Bangkok).

Asia Pacific United Nations Prevention of Parent to Child Transmission of HIV and AIDS Task Force (2013), *The 9th Meeting of the Asia-Pacific United Nations Task Force for the Prevention of Parents-to-Child Transmission*, 27–29 August 2013, Kathmandu, Nepal (Conclusions and Recommendations).

Asia Pacific United Nations Prevention of Parent to Child Transmission of HIV and AIDS Task Force (2013), *Elimination of New Paediatric HIV Infections and Congenital Syphilis in Asia-Pacific. An Advocacy Toolkit*.

ATHENA (2009), *10 reasons why criminalization of HIV exposure or transmission harms women*, at http://www.athenanetwork.org/resources.html.

Attia et al. (2009), "Sexual transmission of HIV according to viral load antiretroviral treatment: Systematic review and meta-analysis," *AIDS* 23.

AVERT (n.d.), *Sex Workers and HIV/AIDS*, at http://www.avert.org/sex-workers-and-hivaids.htm.

AVERT (n.d.), *Transgender People and HIV/AIDS*, at http://www.avert.org/transgender-hiv.htm.

Azim et al. (2006), "Vulnerability to HIV infection among sex worker and non-sex worker female injecting drug users in Dhaka, Bangladesh: Evidence from the baseline survey of a cohort study," *Harm Reduction Journal* 3.33.

Baral et al. (2013), "Worldwide burden of HIV in transgender women: a systematic review and met-analysis," *The Lancet Infectious Diseases* 13.

Barr et al. (2011), "Articulating a rights-based approach to HIV treatment and prevention interventions," *Current HIV Research* 9).

Bengtsson et al. (2013), "Sexual relationships among men who have sex with men in Hanoi, Vietnam: A qualitative interview study," *BMC Public Health* 13.108.

Benoit et al. (2013), "Benefits and constraints of intimate partnerships for HIV positive sex workers in Kibera, Kenya," *International Journal for Equity in Health* 12.76.

Berry, S. et al. (2012), "I'm Proud of My Courage to Test": *Improving HIV Testing and Counseling Among Transgender People in Pattaya, Thailand* (Arlington, Virginia: AIDSTAR-One Case Study Series).

Bhattacharjya, M., Fulu, E. and Murthy, L. with Seshu, M.S., Cabassi, J. and Vallejo- Mestres, M. (2015). *The Right(s) Evidence – Sex Work, Violence and HIV in Asia: A Multi- Country Qualitative Study* (Bangkok: UNFPA, UNDP and APNSW (CASAM).

Bott and Obermeyer (2013), "The social and gender context of HIV disclosure in sub-Saharan Africa: A review of policies and practices," *SAHARA Journal* 10.1, Jul 2013.

Chakrapani et al. (2011), "Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India," *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV* 23.12.

Chakrapani, V., P. Boyce, P., and D. Dhanikachalam (2011), *Women partners of men who have sex with men (MSM) in India* (New Delhi, India: Futures Group International); *India 'MSM Situation Paper' series; Technical Brief 2*.

Chakprani et al. (2007), *Sexual and Reproductive Health of People Living with HIV in India: A Mixed Methods Study*, (Chennai, India).

Chemnasiri et al. (2010), "Inconsistent condom use among young men who have sex with men, male sex workers, and transgenders in Thailand, *AIDS Education and Prevention*, 22.2.

Choi, S. Y. P., Y. W. Cheung, and K. Chen (2006), "Gender and HIV Risk Behavior Among Intravenous Drug Users in Sichuan Province, China," *Social Science and Medicine* 62.

Choopanya, K. et al. (2013), "Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir Study): A randomised, double-blind, placebo-controlled phase 3 trial," *The Lancet* 381.9882, 15 June 2013.

Commission on AIDS in Asia (2008), *Redefining AIDS in Asia: Crafting an Effective Response* (New Delhi: Oxford University Press).

Curran et al. (2012), "HIV-1 Prevention for HIV-1 Serodiscordant Couples," *Current HIV/AIDS Reports*. 9.2, June 2012.

Decker et al. (2010), "Indian men's use of commercial sex workers: prevalence, condom use, and related gender attitudes," *Journal of Acquired Immune Deficiency Syndromes* 53.

Decker et al. (2009), "Intimate partner violence functions as both a risk marker and risk factor for women's HIV infection: Findings from Indian husband-wife dyads," *Journal of Acquired Immune Deficiency Syndromes* 51.

Delvaux et al. (2009), "Determinants of nonadherence to a single-dose nevirapine regimen for the prevention of mother-to-child HIV transmission in Rwanda," *Journal of Acquired Immune Deficiency Syndrome* 50.

Ditekemena et al. (2012), "Determinants of male involvement in maternal and child services in sub-Saharan Africa: A review," *Reproductive Health* 9.32.

Dunkle, K. L. and M. R. Decker (2013), "Gender-based violence and HIV: Reviewing the evidence for links and causal pathways in the general population and high-risk groups," *American Journal of Reproductive Immunology* 69, Suppl. 1, 2013.

Edwards-Jackson et al. (2012), "HIV serostatus disclosure is not associated with safer sexual behavior among HIV-positive men who have sex with men (MSM) and their partners at risk for infection in Bangkok, Thailand," *AIDS Research and Therapy*. 9.1.

Gaffey, M. F., S. Venkatesh, S., and N. Dhingraetal (2011), "Male use of female sex work in India: A nationally representative behavioural survey," *PLoS ONE* 6.7.

García, M. C., S. B. Meye, and P. Ward (2012), "Elevated HIV prevalence and risk behaviours among men who have sex with men (MSM) in Vietnam: A systematic review," *BMJ Open* 2: e001511.doi:10.1136/bmjopen-2012-001511.

Ghimire et al. (2013), "Vulnerability to HIV infection among female drug users in Kathmandu Valley, Nepal: A cross-sectional study," *BMC Public Health* 13.

Gilfus, M. E. et al. (2010), "Gender and intimate partner violence: Evaluating the evidence," *Journal of Social Work Education* 46.2.

Global Network of People Living with HIV/AIDS and UNAIDS (2011), *Positive Health, Dignity and Prevention: A Policy Framework* (The Netherlands).

GNP+, ICW Global, IPPF, UNAIDS (2011), *The People Living with HIV Stigma Index: Asia Pacific Regional Analysis 2011* (Bangkok).

Gouws et al. (2012), "Focusing the HIV response through estimating major modes of HIV transmission: A multi-country analysis," *Sexually Transmitted Infection* 88.

Grote et al. (2012), *Reaching Key Populations in HIV/SRH Integration: Recommendations from a global intervention review to identify strategies to increase the responsiveness and relevance of integrated programming to the sexual and reproductive health and rights and needs of high-risk groups, including sex workers, MSM, transgenders, IDUs and PLHIV*. India HIV/AIDS Alliance (New Delhi).

Guadamuz et al. (2011), "HIV prevalence, risk behavior, hormone use and surgical history among transgender persons in Thailand," *AIDS and Behavior* 15.

Hammett et al. (2012), *HIV risk and HIV prevention among female sexual partners of IDUs in Viet Nam* (Ha Noi); Poster Exhibition XIX International AIDS Conference: Abstract no WEPE326.

Hammet et al. (2012), "HIV prevention interventions for female sexual partners of injection drug users in Hanoi, Vietnam: 24-month evaluation results," *AIDS Behaviour* 16.

Hammett and Khuat (2014), *HIV Prevention for Female Sexual Partners of People Who Inject Drugs (PWID) in Vietnam* (Abt Associates, Inc.).

Haritavorn, N. (2014), "Surviving in two worlds: Social and structural violence of Thai female injecting drug users," *International Journal of Drug Policy* 25.

Higgins et al. (2010), "Rethinking Gender, Heterosexual Men, and Women's Vulnerability to HIV/AIDS," *American Journal of Public Health* 100.

HIV risk in spouses of IDUs and sex workers in Pakistan (2007), Presented at the 17th meeting of the International Society for Sexually Transmitted Diseases Research, Seattle, Washington, 30 July–1 August 2007.

Hong et al. (2013) "Partner Violence and Psychosocial Distress among Female Sex Workers in China," *PloS ONE* 8.4.

India HIV/AIDS Alliance (2012), *HIV/SRHR Integration for Key Populations: A review of experiences and lessons learned in India and globally* (New Delhi).

International HIV/AIDS Alliance et al. (2014), *Lessons Learned from HIV and AIDS Work with People Who Use Drugs in Asia and Eastern Europe* (Brighton, UK).

International HIV/AIDS Alliance (2014), *Link Up Project Overview: Better Sexual and Reproductive Health and Rights for Young People Most Affected by HIV* (Brighton, UK).

Jayaraman et al. (2013), Demographic changes and trends in risk behaviours, HIV and other sexually transmitted infections among female sex workers in Bangalore, India, involved in a focused HIV preventive intervention," *Sexually Transmitted Infections* 89.8, Dec 2013.

Jia et al. (2013), "Antiretroviral therapy to prevent HIV transmission in serodiscordant couples in China (2003–2011): A national observational cohort study," *The Lancet* 382.9899, 5 Oct 2013.

Kato et al. (2013), "The Potential Impact of Expanding Antiretroviral Therapy and Combination Prevention in Vietnam: Towards Elimination of HIV Transmission," *Journal of Acquired Immune Deficiency Syndrome* 62.5.

Kermode et al. (2009), "Killing Time with Enjoyment: A Qualitative Study of Initiation into Injecting Drug Use in North-East India," *Substance Use and Misuse* 44.8.

Kiarie et al. (2003), "Compliance with antiretroviral regimens to prevent perinatal HIV-1 transmission in Kenya," *AIDS* 17.

Kimmons (2014), *HIV Rising Among Men Having Sex with Men in Vietnam* (Thomas Reuters Foundation).

Koh et al. (2013), "Sexual practices and HIV prevalence amongst men who have sex with men at a community-based voluntary counseling and testing centre in Malaysia," *ISRN Infectious Diseases*, article ID 247545.

Kumarasamy et al. (2010), "Risk factors for HIV transmission among heterosexual discordant couples in South India," *HIV Medicine* 11.

Lau et al. (2009), "Comparing prevalence of HIV-related behaviours among female injecting drug users (IDU) whose regular sexual partner was or was not IDU in Sichuan and Yunnan Provinces, China," *AIDS Care* 21.7, Jul 2009.

Longfield et al. (2011), "Increasing safer sexual behaviour among Lao kathoy through an integrated social marketing approach," *BMC Public Health* 11.872.

McLaughlin, M. et al. (2013), "Sexually Transmitted Infections among Heterosexual Male Clients of Female Sex Workers in China: A Systematic Review and Meta-Analysis, *PLoS ONE* 8.8, article e71394.

Milloy et al. (2012), "Barriers to HIV treatment among people who use injection drugs: implications for 'treatment as prevention'," *Current Opinion in HIV and AIDS* 7.

Ministry of Health, Pakistan, UNICEF, Research and Development Solutions (2011), *Enhancing VCT and PPTCT Among Female Spouses of HIV Positive Men through Conditional Cash Transfers* (Islamabad).

Ministry of Health, People's Republic of China/UNAIDS/WHO (2011), *2011 Estimates for the HIV/AIDS Epidemic in China* (Beijing).

Mishra et al. (2014), "HIV risk behaviours of male injecting drug users and associated non-condom use with regular female sexual partners in north-east India," *Harm Reduction Journal* 11.5.

Mishra et al. (2013), "Sexual behaviour, structural vulnerabilities and HIV prevalence among female sex workers in Pakistan," *Sex Transm Infect* (published online 14 February 2013).

Mohr et al. (2013), *Risk Factors for HIV transmission in Serodiscordant Couples in Cambodia: A Case Study* (Phnom Penh: KHANA).

Nai Zindagi Trust (2010), *Final Technical Report. HIV prevention, HIV and AIDS diagnostics, treatment, care and support services for married injecting drug users, their wives and children* (Islamabad).

Narayanan et al. (2013), "An exploration of elevated HIV and STI risk among male sex workers from India," *BMC Public Health* 13:1,059.

National AIDS Committee Thailand (2012), *Thailand Global AIDS Response Progress Report*, 2012.

National AIDS Programme, Myanmar/Strategic Information and M&E Working Group (2012), *HIV Estimates and Projections Asian Epidemic Model Myanmar 2010–2015* (Yangon).

National Centre for HIV/AIDS, Dermatology and STDs and partners (2011), *HIV Estimation and Projection 2011, Cambodia* (Phnom Penh).

Naz Foundation International (2010), *Taking Care of Ourselves: Guidelines for MSM living with HIV – The South Asian Context* (India).

NCASC and ASHA Project (2011), *Integrated Biological and Behavioral Surveillance (IBBS) Survey among Female Sex Workers in Kathmandu Valley, Nepal, Round IV-2011* (Kathmandu).

Nemoto et al. (2012), "HIV-related risk behaviours among kathoey (male-to-female transgender) sex workers in Bangkok, Thailand," *AIDS Care* 24.

Ngo et al. (2009), "Male homosexual identities, relationships, and practices among young men who have sex with men in Vietnam: Implications for HIV prevention," *AIDS Education and Prevention* 21.3.

Nguyen et al. (2009), "Clients of Female Sex Workers as a Bridging Populations in Viet Nam," *AIDS and Behavior*, 13.5.

Nasir, S. (2009), *Culture, Local Construct of Masculinity and HIV-Risk Practices among Young Male IDU in a Slum Area in Makassar, Indonesia*. Aids 2031: Mobilizing Social Capital in a World with AIDS, 30 March–1 April 2009, Salzburg, Austria.

Operario et al. (2008), "Sex Work and HIV Status Among Transgender Women: Systematic Review and Meta-Analysis," *Journal of Acquired Immune Deficiency Syndrome* 48.

Operario, D. (2011), "Unprotected Sexual Behaviour and HIV Risk in the Context of Primary Partnerships for Transgender Women," *AIDS and Behavior* 15.3, Apr 2011.

Orne-Gliemann et al. (2013), "Increasing HIV testing among male partners: The Prenahtest ANRS 12127 multi-country randomized trial," *AIDS* 27.

PATH (2012), *Integration of services for HIV/AIDS and sexual and reproductive health: Pilot projects in India have paved the way for wider use of effective models, strategies, and tools* (New Delhi).

PATH (2008), *Strengthening access to sexual and reproductive health services for people with HIV and for people at risk of HIV: research evidence to promote integration or convergence of sexual and reproductive health services into HIV programmes in India* (New Delhi).

Panchanadeswaran et al. (2008), "Intimate Partner Violence is as important as client violence in increasing street-based female sex workers' vulnerability to HIV in India," *International Journal of Drug Policy* 19.2.

Pawa, D. et al. (2013), "Reducing HIV Risk among Transgender Women in Thailand: A Quasi-Experimental Evaluation of the Sisters Program," *PLoS One* 8, e77113.

Petruney et al. (2012), "Meeting the Contraceptive Needs of Key Populations Affected by HIV in Asia: An Unfinished Agenda," *AIDS Research and Treatment*, article ID 792649.

Pinkham et al. (2012), "Developing Effective Health Interventions for Women Who Inject Drugs: Key Areas and Recommendations for Program Development and Policy," *Advances in Preventive Medicine*, article ID 269123.

Prakash, B. (2003), "Reasons for Sexual Promiscuity In Chemically Dependent Respondents and their Awareness and Acceptance of Condom Use," *Indian Journal of Preventive and Social Medicine*. 24.

PSI/FHI (2007), *Let's Go for a Walk: Sexual Decision-making among Clients of Female Entertainment Workers in Phnom Penh, Cambodia* (Phnom Penh).

Quinn et al. (2000), "Viral load and heterosexual transmission of human immunodeficiency virus type 1. Rakai Project Study Group," *New England Journal of Medicine* 342.13.

Ranjan, A. (2013), *HIV prevalence and awareness among wives of rural migrant workers of Muzaffarpur district in Bihar, India* (Ph.D. dissertation).

Rastogi, S. (2014), "Prevalence and Predictors of Self-Reported Consistent Condom Use among Male Clients of Female Sex Workers in Tamil Nadu, India," *Journal of Sexually Transmitted Diseases*, e952085.

Roberts, A., B. Mathers, and L. Degenhardt on Behalf of the Reference Group to the United Nations on HIV and Injecting Drug Use (2010), *Women Who Inject Drugs: A Review of Their Risks, Experiences and Needs* (Sydney, Australia: National Drug and Alcohol Research Centre, University of New South Wales).

Rongkavilit et al. (2007), "Health Risk Behaviors among HIV-Infected Youth in Bangkok, Thailand." *Journal of Adolescent Health* 40.4.

Saktiawati et al. (2013), "I just trust him: The notion of consideration as a barrier to condom use amongst women who inject drugs in Central Java," *World Journal of AIDS* 3, 2013.

Sciortino, R. (2012), *Achieving Contraceptive Security and Meeting Reproductive Health Needs in South East Asia*. Asia Pacific Alliance for Sexual and Reproductive Health and Rights (Bangkok).

Solomon and Solomon (2011), "HIV serodiscordant relationships in India: Translating science into practice," *Indian Journal of Medical Research* 134, Dec 2011.

Spino, A., M. Clark, and S. Stash (2010), *HIV Prevention for Serodiscordant Couples* (Arlington, Virginia: USAID/ AIDSTAR-One).

Steward et al. (2013), "Charting a Moral Life: The Influence of Stigma and Filial Duties on Marital Decisions among Chinese Men who Have Sex with Men," *PLoS ONE* 8.8, e71778.

Stoicescu, C., ed. (2012), *The Global State of Harm Reduction 2012: Towards an Integrated Response* (London: Harm Reduction International).

Stone-Jimenez et al. (2011), *Technical Brief: Integrating Prevention of Mother-to-Child Transmission of HIV Interventions with Maternal, Newborn and Child Health Services* (Arlington, Virginia: USAID AIDSTAR-One, Task Order I).

Stop AIDS Alliance (2012), *Intensify linkages between HIV and sexual and reproductive health and rights for maximum impact: Stop AIDS Alliance policy position*.

Stringer, E. M., B. H. Chi, N. Chintu et al. (2008), "Monitoring effectiveness of programmes to prevent mother-to-child HIV transmission in lower-income countries," *Bulletin of the World Health Organization* 86.1, Jan 2008.

Taylor and Buttenheim, "Improving utilization of and retention in PMTCT services: Can behavioural economics help?," *BMC Health Services Research* 13.406 (2013).

Thanh, D. C., Moland, K. M., Fylkesnes, K. (2009), "The context of HIV risk behaviours among HIV-positive injection drug users in Viet Nam: Moving toward effective harm reduction," *BMC Public Health* 9.04.

Thomas et al. (2011), "HIV in Indian MSM: Reasons for a concentrated epidemic and strategies for prevention," *Indian Journal of Medical Research* 134.

Treat Asia Special Report (2006), *MSM and HIV/AIDS Risk in Asia: What is fueling the epidemic among MSM and how can it be stopped?*

Thuong, N. V. et al. (2005), "HIV in female sex workers in five border provinces of Vietnam," *Sexually Transmitted Infections* 81.

UNAIDS (2013), *HIV in Asia and the Pacific: UNAIDS Report 2013* (Bangkok).

UNAIDS, UNFPA, UNDP, APNSW (2013), *Legal protections against HIV-related human rights violations: Experiences and lessons learned from national HIV laws in Asia and the Pacific* (Bangkok).

UNAIDS, UNFPA, Asia Pacific Network of Sex Workers (2012), *The HIV and Sex Work Collection: Innovative responses in Asia and the Pacific* (Bangkok).

UNAIDS, UN Women (2012), *Fact Sheet. Measuring Intimate Partner Transmission of HIV in Viet Nam: A Data Triangulation Exercise* (Ha Noi).

UNAIDS (2011), *UNAIDS Terminology Guidelines* (Geneva).

UNAIDS (2010), *26th Meeting of the UNAIDS Programme Coordinating Board. Geneva, Switzerland. 22-24 June 2010. Thematic Segment: Sexual and Reproductive (SRH) services with HIV interventions in practice. Background Paper* (Geneva).

UNAIDS (2010), *Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections. A UNAIDS Discussion Paper* (Geneva).

UNAIDS (2009), *HIV Transmission in Intimate Partner Relationships in Asia* (Geneva).

UNAIDS (2009), *HIV Transmission in Intimate Partner Relationships in India* (New Delhi).

UNAIDS, UNDP (2008), *Criminalization of HIV Transmission Policy Brief* (Geneva).

UNESCO, UNFPA, UNAIDS, UNDP, YouthLEAD (2013), *Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services* (Bangkok).

United Nations Viet Nam (2010), *HIV Transmission From Men to Women in Intimate Partner Relationships in Viet Nam: A Discussion Paper* (Ha Noi).

UNDP, WAP+, APN+, SAARCLAW (2013), *Protecting the rights of key HIV-affected women and girls in health care settings: a legal scan. Regional report* (Bangkok).

UNDP (2012), *A report on addressing the SRH needs of MSM and their female partners using existing SRH facilities and/or working in collaboration with existing organizations. Documentation of models that have worked and replicable strategies* (New Delhi).

UNDP, Asia Pacific Transgender Network (2012), *Lost in Transition: Transgender Persons, Human Rights and HIV Vulnerability in Asia and the Pacific* (Bangkok).

UNDP, UNFPA, UNAIDS (2012), *Sex Work and the Law in Asia and the Pacific* (Bangkok).

UNDP, APCOM (2010), *Legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific* (Bangkok).

UNDP (2010), *Hijras/Transgender Women in India: HIV, human rights and social exclusion* (New Delhi).

UNICEF (2012), *Option B and B+: Key considerations for countries to implement an equity-focused approach. Draft for Discussion*.

UNODC (2014), *Impacts of Drug Use on Users and Their Families in Afghanistan* (Kabul).

UNODC and National AIDS Control Organisation, India (2012), *Female Injecting Drug Users and Female Sex Partners of Men who Inject Drugs: Assessing Care Needs and Developing Responsive Services* (New Delhi).

UNODC Regional Office for South Asia (2012), *Access to comprehensive package of services for injecting drug users and their female sex partners: Identification and ranking of barriers in Northeast India* (New Delhi).

UNODC (2010), *Female Drug Use in Pakistan: Mapping Estimates, Ethnographic Results and Behavioural Assessment* (Islamabad).

UNODC (2010), *Prevention, Treatment and Care for Female Drug Users/Injecting Drug Users and Female Prisoners in Pakistan: Information Briefs* (Islamabad).

UNODC (n.d.), at https://www.unodc.org/southeastasiaandpacific/en/topics/hiv-and-aids/overview.html.

Urada et al. (2012), "Condom Negotiations among Female Sex Workers in the Philippines: Environmental Influences," *PLoS ONE* 7.3, e33282.

USAID/PEPFAR (AIDSTAR-One) (n.d.), *Combination Approaches: An Overview of Combination Prevention*, at http://www.aidstar-one.com/focus_areas/prevention/pkb/combination_approaches/overview_combination_prevention.

Van Heerden et al. (2013), "Collecting Maternal Health Information from HIV-Positive Pregnant Women Using Mobile Phone-Assisted Face-to-Face Interviews in Southern Africa," *Journal of Medical Internet Research* 15.6.

Van Landingham, M., J. Knodel, C. Saengtienchai, and A. Pramualratana (1997), "In the company of friends: Peer influence on Thai male extramarital sex," *Social Science and Medicine* 47.12.

Wang et al. (2013), "Heterosexual transmission of HIV and related risk factors among serodiscordant couples in Henan province, China" *Chinese Medical Journal* 19.

Weait, M. (2011), *The Criminalisation of HIV Exposure and Transmission: A Global Review*," Working Paper prepared for the Third Meeting of the Technical Advisory Group, Global Commission on HIV and the Law, 7–9 July 2011.

Wee, S. et al. (2004), "Determinants of inconsistent condom use with female sex workers among men attending the STD clinic in Singapore," *Sexually Transmitted Infections* 80.

Wei et al. (2012), "HIV Disclosure and Sexual Transmission Behaviors among an Internet Sample of HIV-positive Men Who Have Sex with Men in Asia: Implications for Prevention with Positives," *AIDS and Behavior* 16.7, Oct 2012.

Weiss et al. (2008), "Spousal sexual violence and poverty are risk factors for sexually transmitted infections in women: a longitudinal study of women in Goa, India," *Sexually Transmitted Infections* 84.

WHO (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (Geneva).

WHO (2014), *March 2014 supplement to the 2013 consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* (Geneva).

WHO (2013), *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* (Geneva).

WHO (2013), *Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines* (Geneva).

WHO (2013), *Global update on HIV treatment 2013: Results, impact and opportunities* (Geneva).

WHO, UNAIDS (2013), *16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool* (Geneva).

WHO, UNFPA, UNAIDS, NSWP, World Bank (2013), *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions* (Chapter 4) (Geneva).

WHO (2012), *Guidance on Couples HIV Testing and Counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for public health approach* (Geneva).

WHO (2012, Revised), *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* (Geneva).

WHO (2012), *Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV* (Geneva).

WHO (2012), *Male involvement in the prevention of mother-to-child transmission of HIV* (Geneva).

WHO (2012), *WHO-NIH Informal Consultation on Antiretroviral Treatment as HIV Prevention: Implementation Science in Asia*, 26–28 March 2012, Siem Reap, Cambodia (Meeting Report, Executive Summary).

WHO (2011), *Guidelines: Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach* (Geneva).

WHO (2010), *PMTCT Strategic Vision 2010–2015: Preventing Mother-to-Child Transmission of HIV to reach the UNGASS and Millennium Development Goals* (Geneva).

WHO Regional Office for South-East Asia (2010), *HIV/AIDS among Men Who Have Sex with Men and Transgender Populations South-East Asia: The Current Situation and National Responses* (New Delhi).

WHO Regional Office for South-East Asia (2009), *Management of Common Health Problems of Drug Users* (India).

WHO (2009), *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector: Progress report 2009* (Geneva).

Xia Jin et al. (2010), "HIV prevalence and risk behaviours among male clients of female sex workers in Yunnan, China," *Journal of Acquired Immune Deficiency Syndrome* 53.1, Jan 2010.

Youth Voices Count (2014), *The Hidden Dimension: Experience of self-stigma among young men who have sex with men and young transgender women and the linkages to HIV in Asia and the Pacific* (Bangkok).

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