HIV TRANSMISSION IN INTIMATE PARTNER RELATIONSHIPS IN ASIA





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LANGUAGE AND TERMINOLOGY

The term 'HIV transmission in intimate partner relationships' is used to describe the transmission of HIV to women from their long-term male partners who inject drugs, have sex with other men or are clients of sex workers. The term has its basis in terminology used in the field of domestic violence and covers current or former long-term spouses or partners of women. The concepts of intimacy and relationships are central considerations in the dynamics of HIV infection in this context and hence should be highlighted and better understood.

This term was adopted at the second regional technical meeting on Women and HIV convened in February 2009. Other terms usually used to describe this concept include spousal transmission and transmission among married women. Many country reports use a range of terminology, some preferring to use 'spousal transmission of HIV' and others 'intimate partner transmission of HIV' or 'HIV transmission in intimate partner relationships'.

Participants agreed that it was not a matter of mandating particular terminology, but rather encouraging a collaborative process in each country, where stakeholders, including networks of men and women living with HIV, would together review the issues and come to an agreement. The agreed terminology should then be adapted to and translated into the local language. This report uses the term 'HIV transmission in intimate partner relationships'. When the report refers to women and men, it is inclusive of girls and boys.

BACKGROUND

A regional discussion on HIV transmission in intimate partner relationships was initiated by UNAIDS through a regional meeting on Women and HIV in Cambodia in July 2006. Subsequently, UNAIDS convened a satellite session at the 8th International Conference on AIDS in Asia and the Pacific at Colombo in August 2007, and some countries started to work on desk reviews. Following the recommendations of the Commission on AIDS in Asia (2008), the ASEAN Foundation, UNAIDS, UNIFEM and the United Nations Development Programme (UNDP) together initiated the development of the evidence base on HIV transmission in intimate partner relationships in Asia through collaboration between researchers, regional networks of people living with HIV (the International Commission on Women and the Asia Pacific Network of People Living with HIV/AIDS) and the United Nations (UN).

In July 2008 a regional coordination committee consisting of UN (United Nations Population Fund (UNFPA), UNDP, UNIFEM, UNAIDS), networks of people living with HIV and the ASEAN Foundation was formed to oversee the process. UNAIDS, UNIFEM and UNDP provided technical and budget assistance to countries to carry out desk reviews and focus group discussions. A technical meeting in November 2008 that included the Coalition of Asia Pacific Regional Networks on HIV/AIDS (the Seven Sisters) provided space to review data trends and gaps from the country studies, refine the methodologies and develop a regional network for information exchange.

At a second regional technical meeting in February 2009, experts and community members further analysed the emerging data from additional country reports. A regional policy workshop was held in July 2009 that included representatives of AIDS commissions, other UN agencies (the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO)), the Global Fund to Fight AIDS, Tuberculosis and Malaria and stakeholders involved in the previous meetings. Ninety delegates from 15 Asian countries reviewed the evidence base regarding HIV transmission in intimate partner relationships and responded unanimously that this issue had to find a place in national HIV policies and programmes. This report is the outcome of the efforts of all the above partnerships. Owing to their differing social and cultural contexts, Pacific nations were not included in this process. A separate initiative will take place in 2010.

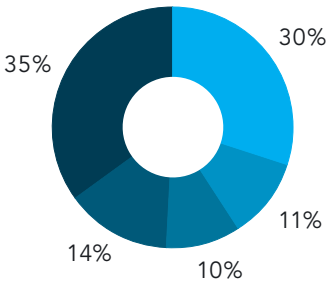
INTRODUCTION

The HIV epidemics in Asia are diverse, complex and heterogeneous, with considerable variation between the countries in the region (Moses et al., 2006), but share important characteristics. The epidemics are centred mainly around unprotected paid sex, the sharing of contaminated needles and syringes by injecting drug users, and unprotected sex among men who have sex with men.

Men who buy sex constitute the largest infected population group. Most men who buy sex either are married or will get married. This puts a significant number of women, often perceived as 'low-risk' because they only have sex with their husbands, at risk of acquiring HIV.

Effective means of preventing HIV infections in the female partners of men with high-risk behaviours have yet to be developed in Asia, but are clearly essential.

Figure 1: Estimated proportions of HIV infections in different poulation groups* in South and South East Asia, 2007



*Specific definitions of these populations may vary by country. India was omitted from this analysis because the scale of its HIV epidemic (which is largely heterosexual) masks the extent to which other at-risk populations feature in the region's epidemics

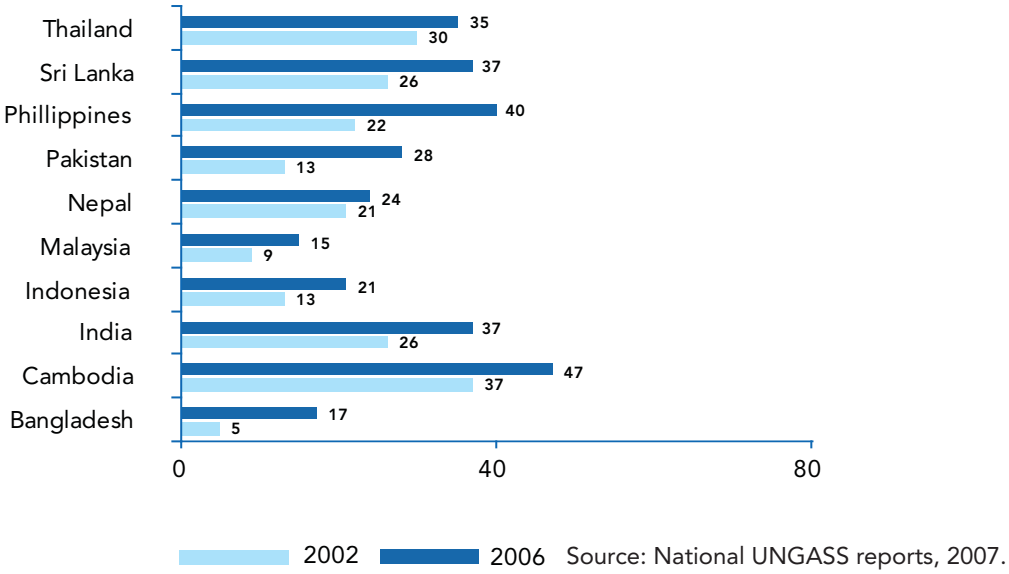
From existing evidence obtained through operational research, it is evident that women in intimate partner relationships are at risk of becoming infected with HIV due to several factors. Although there is some evidence of HIV transmission from women to their intimate male partners, the main focus of this report is on HIV transmission from men to their female partners, as this route of infection is much more common.

OVERVIEW OF THE HIV EPIDEMIC AMONG WOMEN IN ASIA

Data on HIV among women in Asia in intimate partner relationships are limited. Owing to the lack of data on the actual number of women infected by their intimate sexual partners, data on the percentage of all women infected with HIV is presented instead (Figure 2).

These data show that in 2006 the proportion of women infected with HIV was higher than in 2002; for example, in Cambodia the proportion increased to 47% of total HIV infections.

Figure 2: Per cent adults (15+) living with HIV who are women in selected countries of Asian Region, 2002 and 2006



Most women are being infected by their husbands or partners who engage in paid sex or inject drugs. The pattern of HIV infection among women in countries across the region varies according to the phase of the country's HIV epidemic. For example, in epidemics that started in the early 1980s, the proportion of infected women has increased remarkably. By 2007, women constituted 35% of all adult HIV infections in Asia, up from 17% in 1990.

Evidence from many countries in Asia indicates that most women are acquiring HIV not because of their own sexual behaviours but because their partners engage in unsafe behaviours. It is estimated that more than 90% of women living with HIV acquired the virus from their husbands or from their boyfriends while in long-term relationships (Bennetts et al., 1999; Silverman et al., 2008).

Modelling women at risk from their intimate partners

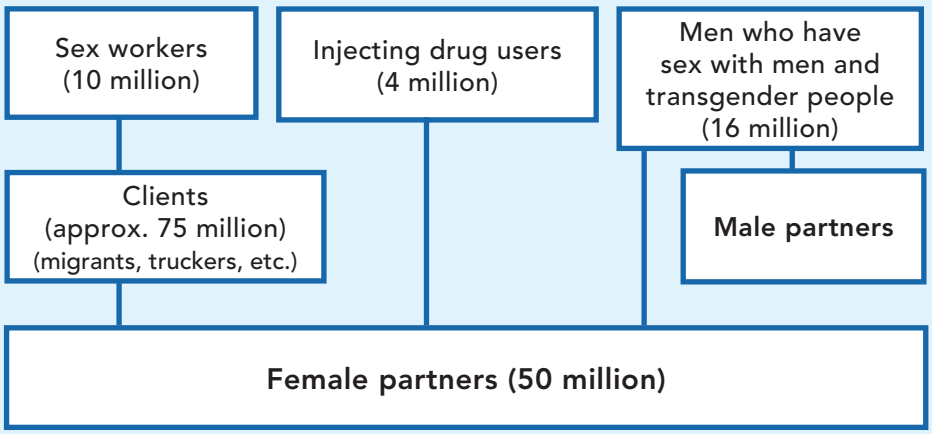
The Report of the Commission on AIDS in Asia (2008) estimates that up to 10 million Asian women sell sex and at least 75 million men buy sex regularly. Male-to-male sex and drug injecting add about 20 million people to the number of men at higher risk of HIV infection. These men may pass HIV on to the male and female intimate partners with whom they have sex regularly.

Although it is difficult to estimate the precise number of men who have sex with men in Asia, due to secrecy surrounding the behaviour and due to stigma in certain cultural contexts, the estimate is that there are approximately 16 million such men (Commission on AIDS in Asia, 2008). Studies in the region indicate that between 10% and 60% of men who have sex with men are either currently married or have regular female partners and do not necessarily identify themselves as bisexual (Baqi et al., 1999; Gibney et al., 2002; Khan, 1996; Mirza and Hasnain 1995).

Between 25% and 60% of male injecting drug users are either married or have a regular female partner. Some studies in Asia indicate that there is considerable cross-over between injecting drug use and transactional sex. For example, studies in Pakistan indicate that between 41% and 50% of male injecting drug users are currently married and at least one fifth of injecting drug users reported having sex with female sex workers. Well over half did not use condoms.

It is estimated that at least 50 million women are at risk of acquiring HIV from their intimate partners (Commission on AIDS in Asia, 2008). These women are either married or are the regular partners of men who engage in higher-risk sexual behaviours.

Dynamics of HIV transmission in intimate partner relationships in Asia

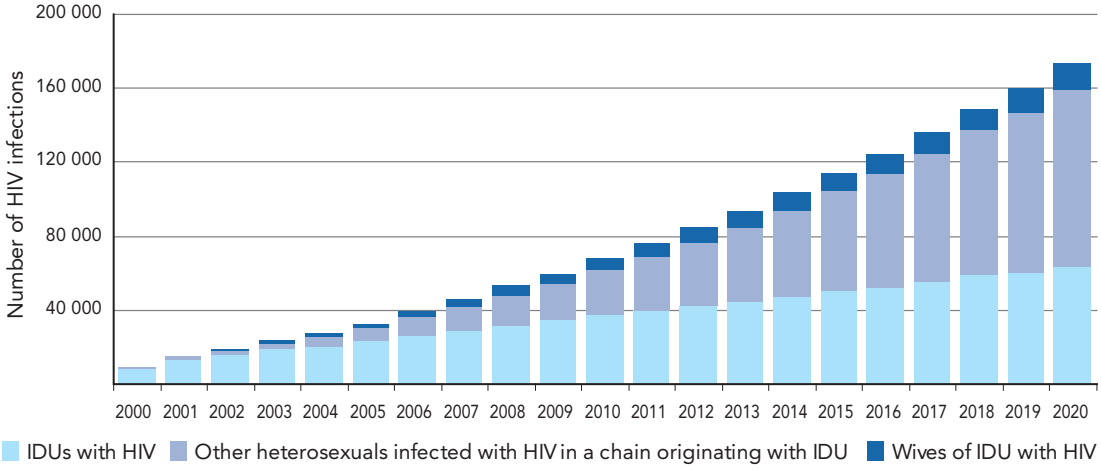


In countries such as Cambodia, India and Thailand, the largest number of new infections occurs among married women. Although paid sex has become safer in Cambodia, the spouses and regular partners of people infected during commercial sex now account for a growing percentage of new infections. Similarly, Thailand's epidemic has diminished but has become more heterogeneous (Over et al., 2007), and HIV is increasingly affecting people considered to be at lower risk of infection. About 43% of new infections in 2005 were among women, the majority of whom were infected by husbands or partners who had had high-risk sex or had used contaminated injecting equipment (World Health Organization, 2007). In India, a significant proportion of women living with HIV have probably been infected by regular partners who bought sex.

In a 2005–2006 survey in Viet Nam, between 20% and 40% of injecting drug users said that they had bought sex in the previous 12 months, and up to 60% said that they regularly had sex with a steady partner. Only a minority (between 16% and 36%) said they consistently used condoms with regular partners (Ministry of Health [Viet Nam], 2006).

Figure 3 projects the long-term effects of the intersection between injecting drug users and their sexual partners in Jakarta, Indonesia, a metropolis in which an estimated 40 000 people inject drugs (Commission on AIDS in Asia, 2008). Although the epidemic was initially powered by HIV transmission among injecting drug users, after about 15 years drug injectors no longer comprise the majority of people infected with HIV. Indonesia's fast-growing epidemic is spreading quickly into sex work networks, including long-term partners and sex workers (Ministry of Health [Indonesia] and Statistics Indonesia, 2007; Statistics Indonesia and Ministry of Health [Indonesia], 2006).

Figure 3: Projected total number of HIV infections in various population groups in Jakarta, 2000–2020



Source: Asian Epidemic Model projections using Jakarta data.

The rate of serodiscordancy in couples underscores the fact that the risk behaviours of men put their monogamous partners at risk of HIV. This is exemplified by data from the National Family Health Survey (NFHS-3) in India, which reveal that in one in every 200 married couples in the country at least one or both partners are infected with HIV (International Institute for Population Sciences, Macro International, 2006). In four in every 1000 married couples, only one of the partners is infected. By extrapolating proportions from survey data to the total number of married couples from data from the 2001 census in the same age group (approximately 236 million married couples in the reproductive age group, according to the census), a conservative estimate of 1.18 million married couples affected by HIV can be obtained. Women are HIV negative in about 0.76 million couples and men are HIV negative in about 0.16 million couples. These data indicate that there is a large cohort of serodiscordant married couples where either the man or the woman is HIV positive. Only 6% of serodiscordant couples in India use condoms consistently.

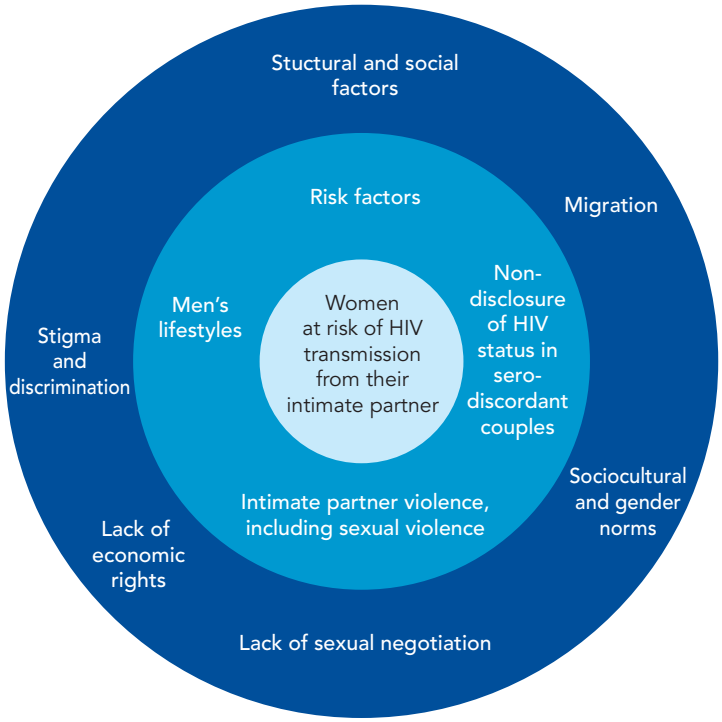
Representative surveys of sexual behaviour in the region have found that very few women report more than one lifetime sexual partner. These findings also highlight that there is a need to carry out better research in order to understand the underlying mechanisms of HIV transmission in Asian countries.

HIV RISK AND VULNERABILITY IN INTIMATE PARTNER RELATIONSHIPS

Preventing HIV transmission within intimate partner relationships requires addressing several factors. As a top priority, HIV prevention interventions among sex workers, men who have sex with men and injecting drug users must be scaled-up and must include a strong additional component of reaching out to their long-term intimate sexual partners.

Other interventions should include preventing intimate partner violence, including sexual violence, promoting gender equality, reducing economic inequities, promoting property rights, reducing vulnerability conditions associated with migration, reducing stigma and discrimination, and improving disclosure within serodiscordant couples. Research on these issues is, however, limited in many Asian countries. The current understanding of these issues is drawn mainly from studies conducted in Cambodia, India, Indonesia, Nepal and Thailand (Maher, 2008; Nepal, 2007; Saggurti et al., 2008; Schensul et al., 2006; Schensul et al., 2009; Silverman et al., 2007a; Sivaram, 2006; Taraphdar et al., 2007; Tu Anh et al., 2009). Figure 4 illustrates a causal model showing the linkages among factors influencing HIV transmission in intimate partner relationships.

Figure 4: A causal model showing the linkages among factors influencing HIV transmission in intimate partner relationships



Patriarchal gender norms

The strong patriarchal culture in the countries of Asia greatly limits the ability of women to negotiate sexual behaviour in intimate partner relationships. For example, while there is a societal toleration of extramarital sex and multiple partners for men in these societies (Roberts, 2009; Sivaram et al., 2006), women are generally expected to refrain from sexual relations until marriage and remain monogamous thereafter. Women and men have little accurate information about sexual issues. Multiple sexual relationships are often viewed as a symbol of masculinity.

Intimate partner violence, including sexual violence

Research from several countries in Asia indicates that between 15% and 65% of women experience physical and/or sexual violence in intimate partner relationships. While the proportion varies among these countries, research across all countries shows that the problem is serious and action is needed to prevent intimate partner violence in an effort to stop HIV transmission in such relationships (Gilbert et al., 2007; Martin et al., 1999; Schensul et al., 2006; Silverman et al., 2007a, 2007b).

The links between intimate partner violence and HIV and between intimate partner violence and the extramarital behaviour of husbands were evident from studies conducted in Bangladesh, India and Nepal. The demographic and health survey in India showed that HIV prevalence was more than four times higher among married women who experienced both physical and sexual violence by an intimate partner than among non-abused women (International Institute for Population Sciences, Macro International, 2007; Silverman et al., 2008). Additional analysis of these data indicated that abusive men were almost twice as likely to acquire HIV infection outside their marital relationships and that their wives are consequently at a greater risk of HIV infection. Intimate partner violence appears to facilitate transmission of HIV within marriage. Women exposed to intimate partner violence from husbands exposed to HIV through regular unprotected multiple partner sex had a seven-times higher HIV risk compared with women not exposed to intimate partner violence and whose husband did not have sex with multiple partners (Decker et al., 2009).

Migration and mobility

There is an unprecedented mobility and migration of populations in the region, fuelled by robust and consistent economic growth in the past decade, which is likely to continue in the future. There is a growing body of evidence that migrants and mobile people are more vulnerable to HIV than are populations that do not move. The Report of the Commission on AIDS in Asia stated that "the future of Asia's epidemics depends to a considerable extent on what happens to men's incomes and their mobility outside family settings. Men who have disposable income, and who travel or migrate to work opportunities, provide most of the demand for commercial sex".

Women and men have different experiences in relation to migration during the different phases of migration (UNAIDS, 2009). In Cambodia, migration often leads men and women to break from traditional norms, where men have multiple partners and use drugs and women engage in paid sex (Roberts, 2009, page 19; Tu Anh et al., 2009, page 16).

Most migrants are separated from spouses and families and from the sociocultural norms that guide behaviour in stable communities. This, added to poor working and living conditions without recreational activities, may lead to isolation and stress. As a result, migrants may turn to having unsafe casual and commercial sex, increasing their risk of acquiring HIV (UNAIDS, 2008). A study in Viet Nam showed that married migrant workers reported having commercial sex partners and low condom use (Tu Anh et al., 2009, page 16). A study in the urban slum communities of Mumbai, India, has shown that married men with occupational mobility and who live separately from their wives have a two and half times increased risk of engaging in extramarital sex than non-mobile men with residential wives (Saggurti et al., 2009).

A number of studies have demonstrated that men in the mobile workforce often have higher HIV prevalence than less-mobile or non-mobile men. Migrant workers from the Lao People's Democratic Republic, the Philippines and Sri Lanka are reported to have high rates of HIV. International migration among countries in the South Asia region is on the rise, with Maharashtra in India being a major destination (Nepal, 2007; Gurung, 1998). Recent research on Nepali migrants to Maharashtra documents a high prevalence of HIV and syphilis among male returnees to Nepal (Gurung, 1998); these infections are presumed to occur from contact with sex workers in India (Poudel et al., 2003).

The female partners of migrant workers have been shown to be at an increased risk of infection when the latter return from working in countries with a high HIV prevalence. Women left behind by their migrant husbands may engage in risky behaviours in order to survive, thereby increasing their risk of contracting HIV, and when their partners return their risk of acquiring HIV again increases. Rural women left behind in China are economically dependent on their migrant husbands and have a poor understanding of HIV transmission. They are usually under societal pressure to give birth and do not use condoms, while those who have already given birth use long-term contraceptives instead of condoms, which poses a risk of HIV if the migrant husband is infected.

Vulnerabilities of migrants and their sexual partners (UNAIDS, 2009)

Social vulnerability, which includes poverty, lack of legal protection, exploitation, harassment, discrimination against migrants, xenophobia, gender discrimination and a lack of power.

Individual vulnerability, which includes lack of negotiating power, separation from families, partners, communities and norms, loneliness, alienation, despair and willingness to take risks.

Programme vulnerability, which includes lack of access to prevention, treatment, care and support.

The interaction of these vulnerabilities is likely to lead to an increased risk of acquiring HIV.

Reducing stigma and discrimination to promote HIV testing and disclosure among couples

Stigma and discrimination based on HIV status, in combination with deeply rooted stigmatizing attitudes and discriminatory practices towards women, men who have sex with men, transgender people, sex workers and drug users, among others, creates conditions for HIV to flourish. For example, fear of stigma and discrimination prevents people vulnerable to HIV from seeking testing (International Council of AIDS Service Organizations, 2007). Ignorance about one's HIV status increases the person's and their intimate partners' vulnerability to HIV infection. Fear of stigma and discrimination also adversely affects the ability and willingness of people to disclose their HIV test results to others.

When HIV programmes largely focus on sex work, drug use and male-to-male sex, it contributes to low HIV risk perceptions in the general population. Intimate partners are often left out and there is lack of couple communication about sexual matters (Chatterjee et al., 2006; Schensul et al., 2009).

WAY FORWARD: THE FRAMEWORK FOR ADDRESSING HIV TRANSMISSION IN INTIMATE PARTNER RELATIONSHIPS

There are significant levels of transmission of HIV from men to their intimate partners. Analysis of the factors associated with HIV transmission in intimate partner relationships and of feasible intervention strategies points to four major recommendations:

1. HIV prevention interventions must be scaled-up for men who have sex with men, injecting drug users and clients of female sex workers and should emphasize the importance of protecting their regular female partners.
2. Structural interventions should be initiated to identify and address the needs of vulnerable women and their male sexual partners.
3. HIV prevention interventions among mobile populations and migrants must be scaled-up and include components to protect intimate partners.
4. Priority should be given to operations research to develop a better understanding of the dynamics of HIV transmission in intimate partner relationships.

HIV prevention interventions must be scaled-up for men who have sex with men, injecting drug users and clients of female sex workers and should emphasize the importance of protecting their regular female partners.

- Ensure provision of sexual and reproductive health services for men who have sex with men, injecting drug users and clients of female sex workers and their intimate partners.
- Address the issues of masculinity and gendered identities for men.
- Build partnerships with local private health practitioners to address the needs of men who have sex with men, injecting drug users, clients of female sex workers and their intimate partners.
- Engage people living with HIV to meet their sexual and reproductive health and treatment needs.

Structural interventions should be initiated to identify and address the needs of vulnerable women and their male sexual partners.

- Engender sexual and reproductive health and HIV programmes through initiating interministerial and interdepartmental coordination of gender-specific initiatives into sexual and reproductive health and HIV programmes.
- Widen the scope of reproductive health programmes to include services for male sexual health.
- Train the rural workforce employed in sexual and reproductive health programmes.
- Integrate treatment programmes for AIDS-related illnesses and programmes addressing mother-to-child transmission into rural health systems, in order to ensure sustainability and the lowering of transaction costs for service provision.

- Promote condom use as dual protection for both HIV/sexually transmitted infections and unplanned pregnancies.
- Encourage governments to take responsibility for the provision of life-skills education and sexual and reproductive health/HIV counselling for young people through relevant sectoral programmes.
- Develop indicators and mechanisms for monitoring gender sensitiveness of sexual and reproductive health and HIV services.
- Address male behaviour and issues of masculinity in programmes for men, especially around intimate partner violence and sexual violence.
- Reduce stigma and discrimination to promote voluntary HIV testing and disclosure among couples.

Strengthen interventions to reduce vulnerability to HIV of mobile populations and migrant workers.

- Dialogue among key ministries within countries (e.g. health, interior, justice, labour, social welfare, education), between different provinces or states of a given country and across national boundaries should be encouraged in order to formulate policies and programmes to promote the protection of human rights for migrants and to provide coherent and consistent access to HIV prevention, treatment, care and support.
- Accurate information on the impact of migration on HIV intimate partner transmission should be gathered by methods that protect human rights, build trust and do no harm.
- Pre- and post-departure programmes should include components on the prevention of HIV transmission to intimate partners.
- Orientation on HIV transmission to intimate partners should be organized for key stakeholders, such as immigration officials, social welfare policy-makers and health service providers.

Priority should be given to operations research to develop a better understanding of the dynamics of HIV transmission in intimate partner relationships.

Further operational research on HIV and intimate partner relationships is needed in order to better understand this complex multidimensional issue. The specific areas of research could include:

- The magnitude of serodiscordance in the country.
- The linkages between risk behaviours of men who have sex with men, injecting drug users, clients of sex workers and their intimate partners.
- The extent to which HIV is transmitted from migrant men to their intimate partners between destination and source areas and from rural to urban areas.
- The challenges in interventions targeted to men who have sex with men, injecting drug users and clients of sex workers in promoting partner notification and the prevention of HIV transmission in intimate sexual partner relationships.

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