



## POLICY AND PROGRAMMING IMPLICATIONS

Programs working on HIV prevention among IDU in low resource settings can consider the following steps to support partner notification of HIV status:

Most programs are working primarily with male IDU. Programs can **encourage male clients to bring their wives for couples counselling and testing.**

Programs that work with women IDU can **encourage participation of husbands in ante-natal care visits** and provide access to couples counselling and testing in the context of ante-natal care.

Programs that provide home-visits can **offer couples counselling and testing in the families of male IDU and female IDU.**

All programs can **provide information, counselling and condoms** to support safe sexual practices in discordant marriages.

All programs can **provide support on safe conception for HIV discordant couples.**

Programs can provide **support in the case of negative consequences of partner disclosure** such as counselling and support on domestic violence, access to safe homes for spouses who experience negative consequences, and on-going couples counselling.

As much as possible, **linking counselling for IDU to care, support and treatment**, can improve acceptability of couples counselling, disclosure rates, and safer sexual practices.

## BACKGROUND

Most injecting drug users in South Asia are men, most are married, most spouses of IDU in South Asia do not inject drugs, and the majority of HIV-positive male IDU are in discordant marriages-meaning the husband is HIV-positive and the wife is HIV-negative. Male IDU may access HIV testing services and learn their HIV status, but be reluctant to disclose their status to their spouse. In addition, expansion of HIV testing in ante-natal settings means that growing number of spouses of male IDU may be accessing HIV testing and learn their status prior to their husband being tested. Preventing HIV transmission to the wives of male IDUs and supporting safe sexual practices in marriage thus requires support for disclosure of HIV status in couples affected by drug use. This Information Brief provides basic information about discordancy and simple steps that service providers can take to support disclosure of HIV status and safe sexual practices in the context of marriage.

## WHAT ARE THE ISSUES?

### The majority of HIV-positive male IDU in South Asia are in discordant marriages:

The majority of IDUs in South Asia are married men, and research has found high rates of marital discordancy among male IDU—a situation in which the husband is HIV-positive and the wife is HIV-negative. A study in Manipur, India, found that 65 percent of HIV-positive male IDU were in discordant marriages,<sup>1</sup> and in Pakistan, a study found that 85 percent of HIV-positive male IDU were in discordant marriages in Faisalabad, 90 percent in Lahore and 95 percent in Sargodha.<sup>2</sup>

### HIV-positive men tend to be less likely than HIV-positive women to disclose their status to their sexual partners:

There are no studies that quantify disclosure rates among male IDU to their spouses, however studies in India have found that HIV-positive non-IDU men are less likely to disclose their status to their sexual partners than are HIV-positive women: A study of PLHIV in Kolkota found that all the female participants had disclosed their HIV status to their sexual partners, but only 65 percent of the men had done so; among married men, the rates of disclosure were higher—82.3 percent had disclosed their HIV status to their sexual partners.<sup>3</sup>

### Fear of the negative consequences are a barrier to disclosure:

Fear of negative outcomes of disclosure is a significant barrier to disclosure for both men and women. Possible negative outcomes include blame, abandonment, violence, anger, stigma and depression.

### Women are more likely than men to experience negative consequences, such as violence, when they disclose their HIV status:

In the Kolkota study, 16.6 percent of women reported negative outcomes following disclosure of their HIV-positive status, compared to 11.5 percent of men.<sup>4</sup> Another study found that women particularly feared accusations of infidelity, abandonment, discrimination and violence, and that between 3.5 percent and 14.6 percent of women reported experiencing a violent reaction from a partner following disclosure.<sup>5</sup> A study from Lusaka, Zambia, showed that many people expressed worries about sharing HIV test results, such as being ashamed of being HIV positive or of having gone for a test; those who were seronegative said that even going for a test would make their partner suspicious, and some said that they feared blame, abandonment or abuse if their partner found out they were HIV positive. Women more commonly expressed these concerns.<sup>6</sup> In Zimbabwe, informing husbands was also found to be a major problem for most people with HIV.<sup>7</sup> The main reasons for non-disclosure were relatively good health and emotional status, denial of diagnosis, fear of rejection, limited knowledge of and belief in strategies to “live positively with HIV,” unacceptability of condoms and safer sex, and women’s economic dependency and lack of power in sexual situations.



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<sup>1</sup>Panda et al. 2000. Transmission of HIV from injecting drug users to their wives in India, International Journal of STD & AIDS 11 pp. 468-473

<sup>2</sup>Naizindagi, The Hidden Truth, 2008

<sup>3</sup>Pranita Taraphdar, Aparajita Dasgupta, B Saha. 2007. Disclosure Among People Living with HIV/AIDS, Indian Journal of Community Medicine Vol. 32, No. 4, October.

<sup>4</sup>Pranita Taraphdar, Aparajita Dasgupta, B Saha. 2007. Disclosure Among People Living with HIV/AIDS, Indian Journal of Community Medicine Vol. 32, No. 4, October.

<sup>5</sup>Medley A, Garcia-Moreno C, McGill S, Maman S. 2004. Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes, Bull World Health Organ. Apr; 82(4):299-307.

<sup>6</sup>Baggaley R, Kelly M, Mulongo W. 1997. To tell or not to tell: sharing HIV results with sexual partners., presented at the 5th SANASO conference, Mbabane, Swaziland, October, Abstract W322D.

<sup>7</sup>Meursing K, Sibindi F. 1995. Condoms, family planning and living with HIV in Zimbabwe. Reproductive Health Matters, 5:56-62.

## Supporting safe and beneficial disclosure of HIV status for married IDU in low-resource settings-focus South Asia

### **Growing availability of provider-initiated HIV testing in antenatal settings means that spouses of IDU may be more likely to be tested before their husband:**

Women who test positive in the antenatal setting may be especially apprehensive to disclose their status to their husband for fear of rejection at an especially vulnerable time-when they are pregnant. In a small study from the Western Cape in South Africa less than 50 percent of HIV positive women tested in ante-natal care were able to disclose their HIV status to anyone and only a minority of those who did disclose, discussed it with their partner.<sup>8</sup> In the MTCT programme in Botswana disclosure to partners has also been reported as being low and very few men were either tested together with their wives or agreed to test at a later date.<sup>9</sup>

### **The desire to have children together with limited or no access to modern technologies**

## **EVIDENCE: GOOD PRACTICES**

### **Support “beneficial disclosure:”**

UNAIDS and WHO support “beneficial disclosure” which is defined as “disclosure that is voluntary; respects the autonomy and dignity of the affected individuals; maintains confidentiality as appropriate; leads to beneficial results for those individuals, and for their families and sexual and drug-injecting partners; leads to greater openness in the community about HIV/AIDS; and meets the ethical imperatives of the situation where there is need to prevent onward transmission of HIV.”<sup>11</sup>

### **Provide “ethical partner counselling:” UNAIDS and WHO support ethical partner counselling which is based on the informed consent of the source client.<sup>12</sup>**

### **Provide counselling and education to PLHIV:**

A project in the United Republic of Tanzania provided counselling and education to PLHIV and found that HIV status disclosure (to anyone) increased from 18.8 percent at baseline to 84.4 percent at the 12-month follow-up.<sup>13</sup>

### **that allow discordant couples to safely conceive children discourages disclosure (and condom use) in marriage:**

For some couples, the need to have children may be seen as a greater priority than preventing HIV transmission. Thus HIV positive women may risk HIV transmission to an HIV negative partner or an HIV negative women may risk acquiring HIV transmission from an HIV positive partner.<sup>10</sup> Social beliefs that HIV-positive women should not conceive children or are not capable of caring for a child, also discourage disclosure among women who want to have children. Advanced technologies such as sperm-washing and invitro-fertilization, that allow for safe conception in discordant or HIV-positive couples, are not widely available in low resource settings. Similarly, technologies for assessing viral load counts-key to supporting safe conception in discordant or HIV-positive couples-are not widely available in low-resource settings.

### **Provide disclosure support in the context of condom promotion in families:**

A project in China focused on condom promotion within families and found that HIV status disclosure to spouses increased from 3.6 percent at baseline to 11.9 percent at follow-up; disclosure rates improved but remained low.<sup>14</sup>

### **Provide VCT and access to treatment:**

Creating incentives that encourage testing-such as providing support, treatment and care-supports beneficial disclosure and encourage people to undergo testing.<sup>15</sup> The above-cited study in Kolkota involved PLHIV who participated in a voluntary counselling and testing program at the School of Tropical Medicine where treatment for HIV was available. This study found that a majority of participants-87.5 percent, reported positive outcomes following disclosure, including kindness, understanding and acceptance, and that disclosure was not associated with break-up of marriages.<sup>16</sup>

### **Provide access to couples counselling and testing:**

Couples counselling and testing overcomes the problems of disclosure to partners and has been a successful intervention where it has been promoted.<sup>17</sup> In Pakistan, Naizindagi's study of spouses of male IDU provided testing for male IDU together with their spouses<sup>18</sup> Couples counselling and testing aims to support the couple to negotiate appropriate changes in sexual behaviour together. It also helps them plan together for their future and that of their dependants, with the support of their counsellor at both pre- and post-test. Couples seen together can be counselled to avoid blame and prepared, prior to testing, to make risk assessment and reduction plans together. The majority of studies of couples counselling among discordant couples report successful outcomes in terms of changing behaviour to prevent HIV transmission to negative partners.<sup>19</sup> A couples counselling program in Rwanda found that, compared to other VCT services, a far higher proportion of couples wanted to receive HIV counselling and testing together. Data from Rwanda found that use of VCT services by cohabiting couples was effective at reducing HIV transmission within HIV discordant couples and diminishing new HIV infections in HIV negative couples.<sup>20</sup>

### **Male participation in ANC:**

Because spouses of male IDU may be accessing HIV testing during pregnancy, involving IDU-husbands in antenatal care-such as asking men to attend ANC together with their wives-can provide an opportunity for couples counselling and couples testing. UNAIDS recommends that “innovative ways of involving men in antenatal testing be sought so that women are not blamed or isolated if they are found to be HIV positive. If men can be offered VCT, they can take an informed and active role in decisions around the future, family planning and coping with MTCT interventions.”<sup>21</sup>

### **Low-threshold options for discordant couples to conceive children:**

There are no UN guidelines on safe conception for discordant couples in low resource settings. However, the WHO Medical Eligibility Criteria for Contraceptive Use recommend that HIV-positive sero-concordant couples who plan to conceive a child **apply the method of timing conception at the fertile time of the menstrual cycle** to limit exposure and the risk of re-infection and virus mutation.<sup>22</sup> In January 2008, the Swiss AIDS Commission reported on an analysis of four studies and concluded that **HIV-positive people who received ARVs and have an undetectable viral load do not risk infecting their sexual partners.**<sup>23</sup> In response to this report, UNAIDS noted that “the risk of HIV transmission is lower for people with undetectable viral loads, but ... no study has yet ruled out the risk of HIV infection.”<sup>24</sup>

<sup>8</sup>Sixaxhe T. 2000. Disclosure of HIV status among antenatal women in the Western Cape (MSc thesis)

<sup>9</sup>Mazhani L. et al. 2000. Report of mid-term review of the prevention on MTCT programme of Botswana. MoH/UNICEF, Botswana.

<sup>10</sup>UNAIDS. 2001. The Impact of Voluntary Counseling and Testing: A global review of the benefits and challenges.

<sup>11</sup>UNAIDS. 2000. Opening up the HIV/AIDS epidemic: Guidance on encouraging beneficial disclosure, ethical partner counselling & appropriate use of HIV case-reporting.

<sup>12</sup>UNAIDS. 2000. Opening up the HIV/AIDS epidemic: Guidance on encouraging beneficial disclosure, ethical partner counselling & appropriate use of HIV case-reporting.

<sup>13</sup>MacNeil JM, Mberesero F, Kilonzo G. 1999. Is care and support associated with preventive behaviour among people with HIV? AIDS Care; 11: 537-46

<sup>14</sup>Yang F, Wu Z, Xu C. 2001. Acceptability and feasibility of promoting condom use among families with human immunodeficiency virus infection in rural area of China. Zhonghua Liu Xing Bing Xue Za Zhi; 22: 330-3

<sup>15</sup>UNAIDS. 2000. Opening up the HIV/AIDS epidemic: Guidance on encouraging beneficial disclosure, ethical partner counselling & appropriate use of HIV case-reporting.

<sup>16</sup>Pranita Taraphdar, Aparajita Dasgupta, B Saha. 2007. Disclosure Among People Living with HIV/AIDS, Indian Journal of Community Medicine Vol. 32, No. 4, October.

<sup>17</sup>UNAIDS. 2001. The Impact of Voluntary Counseling and Testing: A global review of the benefits and challenges.

<sup>18</sup>Naizindagi. 2008. The Hidden Truth.

<sup>19</sup>UNAIDS. 2001. The Impact of Voluntary Counseling and Testing: A global review of the benefits and challenges.

<sup>20</sup>Allen S et al. 1993. Pregnancy and contraceptive use among urban Rwandan women after HIV counselling and testing. American Journal of Public Health, 83:705-710.

<sup>21</sup>UNAIDS. 2001. The Impact of Voluntary Counseling and Testing: A global review of the benefits and challenges.

<sup>22</sup>WHO. 2004. Medical Eligibility Criteria for Contraceptive Use 3rd ed. Geneva.

<sup>23</sup>Vernazza P., Hirschel B., Bernasconi E., Flepp M. 2008. Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antiretroviral efficace ne transmettent pas le VIH par voie sexuelle. Bulletin des medecins Suisses 89:5 (Janvier), pp.165-169.

<sup>24</sup>UNAIDS. 2008. Report on the Global AIDS Epidemic, p. 118.