Audience Profile: **Serodiscordant Couples**

Who They Are (and in the Context of HIV)

In a snapshot: in an interrupted relationship.

Serodiscordant couples (SDC) are those in which one partner is HIV positive and the other is HIV negative. Often, these couples are going through a period of disruption—trust issues, blame for bringing HIV into the relationship, disconnection about sex, and despair over the loss of intimacy. Many find themselves in the "discordance dilemma," seeing no way to avoid HIV transmission while preserving their relationship. Even for those who remain loving and committed, the risk of HIV transmission can complicate the things they want and value with their partner. Importantly, discordance can create frustration and despair for couples who want to conceive children—a strong and prevalent desire, sometimes driven by a new sense of mortality.

A big contributor to the spread of HIV.

While SDC are not always recognized as a priority for HIV-prevention interventions, they are a significant population. Recent studies in sub-Saharan Africa show that of all couples in which at least one partner has HIV, up to two-thirds are serodiscordant. In Kenya, for example, the 2009 Modes of Transmission Report showed there were an estimated 260,000–350,000 SDC in the country, which included approximately 190,000 uninfected female partners and 160,000 uninfected male partners.[1] Similarly across sub-Saharan Africa—and contrary to the common perception that the man is always the HIV-positive partner—a 2016 USAID report showed that the woman is the HIV-positive partner in about 30 to 40 percent of SDC.[2]

HIV-negative partners are living with repeated risk of HIV transmission over time.[3] Sexual transmission from an HIV-infected partner who is not virally suppressed puts them at risk. One analysis estimated that between 55 and 92 percent of new, heterosexually acquired HIV infections among adults occurred within serodiscordant marital or cohabitating relationships.[2]

The following is an overview of research about SDC, summarizing a broad array of recent studies conducted in communities and countries across sub-Saharan Africa. While this document references broad trends and similarities within this group, there are important distinctions between SDC in different countries and contexts—even from one neighborhood to the next. When used to inform a communications campaign, this should be a starting point for further investigation, including research engagement with local audiences for whom PrEP is an option.

Priorities, Worries, Dreams, Aspirations

When designing a communications program, it's vital to understand the audiences' complex lives. This section explores priorities (not specifically related to HIV) among many SDC, who place family—especially children—high on the priority list; they may struggle with the viability of their relationships due to one partner's HIV status.

SDC prioritize family—and children.

According to quantitative market research completed in Kenya in October 2017 by the OPTIONS consortium, SDC care most about family, health, and financial independence and stability.[4]

While these SDC worried about contracting HIV, it wasn't their top concern; the desire for children superseded HIV risk considerations, even though most of the couples were aware of the risk of horizontal and vertical HIV transmission. Their priorities:

- **Family:** At least 33 percent of respondents wanted to start a family; almost 33 percent wanted to expand their family.
- **Financial independence and stability:** The high cost of living, challenge of saving, and day-to-day struggle of meeting their family's needs preoccupies SDC; next to family, SDC most value the ability to financially support their loved ones.
- **Health:** SDC are likely to look after their bodies, eat a balanced diet, go for regular checkups, practice safe sex, and get regular HIV testing.

When the same 2017 study asked what actions SDC take to achieve their priorities, their responses reflected a general desire for stability. Respondents said they were saving money, seeking to own property, and hoping to provide a stable home for their children.

SDC wrestle with the "discordance dilemma," wondering whether their relationships can continue.

Research in Kenya has found that many SDC struggle between wanting to continue the relationship but fearing infection, loss of health, and early death. Ultimately, SDC may feel that the discordance makes their relationship impossible.[5]

> **"I feel stuck. I love my wife. I want to have sex. I don't like condoms. I don't want to get infected, either…It's not easy. It's difficult. It's a dilemma."[6]** — Uninfected partner in a serodiscordant relationship, Uganda

Despite this dilemma, SDC have a low rate of separation.

For example, according to formative research conducted in Uganda, marriage is culturally valued, socially expected, and considered a permanently binding commitment. Divorce is discouraged by local Christian churches. Once married, a move to separate by either partner will likely be met with objections from family and friends, who may intercede to try to keep the couple together.[7]

Challenges

Any person's risk factors for HIV acquisition are closely tied to the challenges they face. For SDC, relationship challenges may be compounded by social stigma.

Discordance creates ongoing relationship challenges.

SDC commonly report feelings of isolation, fear of disclosing their HIV status, relationship discord over perceived infidelity and blame, and union dissolution across sub-Saharan Africa, according to a 2012 report by

the National Institutes of Health (NIH). In some cases, individuals report physical violence and threats from their partners over refusal to have sex (or refusal to have sex without a condom).[8] According to a review of HIV prevention for SDC in Kenya, disagreements over sex and procreation are common among SDC; the personal desire and family pressure to have more children is a source of stress.[9]

In addition to relationship pressures, SDC may face stigmatization and victimization.

SDC often face the negative perception that both partners are HIV positive. The 2017 OPTIONS research in Kenya found that three in ten SDC feel they have been stigmatized or victimized in some way. Reported stigmatization primarily revolves around being HIV positive; SDC also experience gossip, verbal abuse, and harassment, as well as social isolation (as people may refuse to share objects with them or refuse to associate with them).[4]

The psychological stresses presented by the stigma of HIV also create challenges for SDC, and they may lack sufficient social support. One such stressor may be the desire to have children, which opposes the common notion that the infant and HIV-negative partner would necessarily be HIV-infected. In fact, some SDC are also encouraged by their churches to take an HIV test before getting married, especially in Pentecostal and Evangelical faiths.

Relationship to Health & Healthcare

This section examines how SDC think about their health broadly, especially with respect to preventive health practices; it also considers their access to and interactions with formal healthcare. SDC are likely to be very interested in health and prevention, but may face the stigma of HIV from healthcare workers.

SDC are concerned about their health and interested in prevention.

In the 2017 OPTIONS Kenya research, SDC respondents were concerned about their health. The majority of respondents, 66 percent, reported being "very concerned about their health." Among the "very concerned," respondents' fears revolved around recently having unprotected sex. Another 22 percent of respondents were "a bit concerned" about their health. Only 12 percent were "not concerned."[4]

Respondents associate health with safe sex, and mostly believe that "prevention is better than cure."

Interestingly, the top ways to stay healthy reported to the OPTIONS study were related to safe sex: 76 percent said "being faithful to their partner" was a key way to stay healthy and 58 percent said "using male condoms." Other cited ways to stay healthy included "avoiding stress" (60 percent), "eating healthy foods" (51 percent), and "good personal hygiene" (45 percent). When asked whether they live by the concept "prevention is better than cure," 82 percent replied, "I completely live by it."[4]

How SDC Stay Healthy[4]

Many use religious and cultural beliefs to stay healthy.

According to the OPTIONS study, almost one in every two SDC surveyed in Kenya rely on the power of prayer to prevent diseases or remain healthy. However, a large proportion (one in three) also report that they don't have any religious or cultural beliefs that are affecting their health decisions.[4]

SDC primarily seek formal healthcare through government sources.

The majority (72 percent) of SDC surveyed in the OPTIONS Kenya research visit government hospitals or dispensaries, which are free and often conveniently located. About one in three will visit a private clinic. Most individual partners in SDC go to their healthcare visits alone, but they are more likely to go with their partner than are any other potential users of PrEP.[4]

Healthcare workers' bias impacts SDC' willingness to seek care.[5]

SDC may be reluctant to engage with the healthcare system due to their perception of poor treatment associated with HIV-related stigma, as well as long wait times, short visits with providers, and general negative perceptions of service delivery. One study showed that individuals in SDC who were dissatisfied with care, felt they had been treated rudely, or felt that the clinic staff "didn't care" tended to disengage from HIV treatment and prevention.[6]

Bias and lack of information also impacts healthcare workers' interactions with SDC. One study found evidence of healthcare workers lacking the knowledge to support the couple in navigating their status, even advising couples to separate.[5] For couples seeking advice on how to conceive a child, another qualitative study in HIV care and treatment sites in Kenya found that healthcare workers did not share safer conception practices with their clients unless clients initiated the conversation.[10]

In-depth interviews in South Africa revealed similar omissions due either to the healthcare workers' lack of knowledge or to their concern that the clients would misuse the information by taking steps to conceive before the HIV-positive partner was fully virally suppressed.[11]

Due to these challenges, many healthcare workers are not taking the vital first step of initiating conversations about safer conception. Thus the onus is on patients to raise the topic (which is a high barrier), and SDC continue to risk HIV transmission in order to conceive.[11]

However, the previously mentioned qualitative study in Kenya did find that a positive clinical encounter motivated SDC to initiate PrEP: "Many participants described the welcoming environment of the clinic, high-quality services, and positive interactions with study staff as helpful in their decision to take PrEP…Patient-provider dynamics, combined with clear explanations and friendly, nonjudgmental services, were critical to SDC' decisions to initiate PrEP and see a future together."[12]

Relationship to and Engagement in High-Risk Activities

In this section we look at the behaviors and social norms that commonly put SDC at most risk of HIV acquisition.

For SDC, the greatest risk is sexual transmission from an HIV-infected partner who is not virally suppressed.

For a woman, the risk of transmission is about 0.08 percent. That's one transmission for every 161 exposures. For men, the risk of transmission is about 0.04 percent. That's one transmission for every 2,500 exposures.[13] In the context of SDC, prevention options to reduce this risk (apart from abstinence) by over 95 percent include using condoms or ensuring that the HIV-positive partner is virally suppressed.

For people in an SDC, the experience of sexual pressure mostly comes from within the relationship as opposed to externally.

According to the OPTIONS research in Kenya, if a person in an SDC experiences sexual pressure, 88 percent of the time it comes from their partner. At least one in ten SDC surveyed experiences sexual pressure from their spouse or partner "quite often," and are most often forced when they're "not in the mood." Approximately one in five feel that they have to "give in" because "there's nothing (they) can do" but if they can avoid their partners during this time, they will.[4]

Sexual pressure can be intensified by intimate partner violence, which is prevalent. A woman who experiences violence in an SDC may be at greater risk of transmission.

Intimate partner violence is widespread across sub-Saharan Africa. In Kenya, for example, 47 percent of ever-married women aged 15-49 have experienced intimate partner violence.[14] In Zimbabwe, the 2011 Zimbabwe

Demographic and Health Survey (ZDHS) on gender-based violence found that more than a quarter of women with a married or stable partner have experienced physical or sexual violence from their partner.[15]

Some people consider intimate partner violence normal. The 2015 ZDHS on gender-based violence found 39 percent of women thought their husband was justified in beating them for at least one of the following reasons: burning the food, leaving the house without telling him, arguing with him, neglecting the children, or refusing sex with him.[15]

Intimate partner violence may prevent women from being able to negotiate using a condom; for a woman in an SDC, this puts her at higher risk.

Relationship to Sexual and Reproductive Health and HIV Testing, Prevention, and Treatment

This section examines SDC' access to and use of important preventive practices specifically related to HIV. For many in this group, concepts of prevention revolve primarily around condom use, although use may be inconsistent (and may conflict directly with many SDC' strong desire for children).

SDC hold fairly inaccurate perceptions of their risk for HIV.

Only about half of SDC' uninfected partners surveyed considered themselves at risk for HIV. For those who identified as being at risk, their most commonly cited reasons were 1) inconsistent condom use, 2) having more than one partner, and 3) inconsistent HIV testing. Interestingly, 26 percent reported that they were at risk because they "share sharp objects with people."[4]

A majority of SDC have tested for HIV in the past year.[4]

Twenty-five percent test every 4 to 6 months, and one in three had tested more than 12 months ago.[16] The 2017 OPTIONS Kenya research found that when SDC test for HIV, they are equally likely to go to a government or to a private hospital.[4]

Their perception of "safe sex" is focused on condoms.[4]

SDC consider condoms as the way to protect against HIV. In the 2017 OPTIONS research, the number one definition for "safe sex" that SDC offered was condom use; the second option was "having one sexual partner." Approximately one in three SDC believe that being open about their HIV status is a means of prevention.

Notably, very few (almost zero) considered PrEP as something that can help them practice "safe sex." This is a definite opportunity for communications—it is important to define PrEP as a form of practicing safe sex.[4]

Despite reported faith in condoms, in practice, SDC' use of condoms is quite inconsistent.[17]

In practice, a range of challenges prevents consistent and correct condom use. The desire to conceive children is a major deterrent. In one study, although most of the couples were aware of the risk of horizontal and vertical HIV transmission, almost all couples reported that they had intended to become pregnant and that

the desire for children superseded HIV risk considerations.

There is also a desire for intimacy in sex, which can lead couples to forgo condoms. Alcohol is also a common cause of men's inconsistent condom use.

As a result of inconsistent or minimal condom use, the uninfected partner is put at considerable risk if not using PrEP consistently and/or if the HIV-positive partner is not consistently virally suppressed.[3]

Resignation and misconceptions about condom use and HIV transmission are also common.

In one study among SDC in Kenya, women reported frequent condom breakages as a normal occurrence, which made them feel that they had little control over their risk of acquiring HIV and therefore less motivated to use condoms. Practices like wiping lubricant off condoms before sex may contribute to condom breakages. Additionally, the misconception exists that putting on the condom just before ejaculation provides enough protection.[17]

That study also showed misconceptions among SDC about HIV and how it is transmitted. Some respondents expressed fatalistic or faith-based opinions about HIV transmission, believing it is based on luck or an act of God; others believe that God will protect them from HIV.[18] Some also distrust the test and believe in a hidden infection not detectable by HIV tests.[18]

In another Kenya study published in 2014, other misconceptions include the belief that one partner is immune, or that transmission is a consequence of "rough sex," while "gentle sex" will protect HIV-negative partners. There is also belief in a "window period" when the negative partner is safe. Some individuals use substances like bleach or hot water and soap to clean themselves in the hopes of preventing HIV.[17]

Patriarchal dynamics and reduced sexual pleasure also inhibit condom use.

In the 2014 Kenya study, one of the main reasons for a male partner's reluctance to use condoms was reduced sexual pleasure.[17] His wife/partner doesn't necessarily have the power to negotiate it because she may fear[17]:

- **Conflict:** Even suggesting condom use via risk-reduction counseling prompted conflict about fidelity and trust in a clinical trial.
- **Abuse:** Requesting male partners to use condoms can spark anger that leads to verbal abuse, withholding of economic support, and, in extreme cases, physical abuse.
- **Abandonment:** Women can also fear that their male partners will go out to seek new partners so that they can have sex without a condom.

Respondents also reported that their living arrangements are not conducive to arguments about condom use, expressing a sense of resignation and embarrassment:

> **"You have big children, and you spread a sack for the child to lay down there, and you are with your husband. You will not scream because your husband has not put on a condom. You will be forced to give him sex because you fear the embarrassment with the children being around."[17]** — Married woman, Kenya

Relationship and gender dynamics are important factors in sexual health decisions.

Power dynamics may place healthcare decision-making within men's purview, while gendered definitions of labor may leave women to manage day-to-day aspects of healthcare, as shown in a 2016 paper published in the journal AIDS Care. On the one hand, some people believe that the decision for either partner to initiate antiretroviral therapy (ART) or PrEP belongs with the male partner—as one respondent put it, "It's my husband who decides."

At the same time, a cultural belief exists that the healthcare of the family is the woman's responsibility, as one male respondent proclaimed, "Normally it is the woman who comes to the clinic."[19] This gendered dynamic puts women in a precarious position, as they may need to defer to their husbands' wishes while also proactively initiating clinic visits.

Relationship to PrEP

When thinking about how best to influence an audience's behavior and encourage PrEP uptake, it is important to consider five factors: 1) awareness, 2) understanding, 3) benefits, 4) interest, and 5) barriers. This section looks at how SDC currently understand and consider PrEP across these five dimensions:

- *Awareness is high.*
- *Understanding is low to moderate.*
- *Benefits for this audience (perceived) include protection, relationship benefits (greater intimacy, less stress), and the potential to conceive children more safely.*
- *Interest is very strong.*
- *Barriers to uptake include fear of side effects as well as the stigma (i.e., fear that PrEP will be mistaken for HIV treatment medication) and concern about inconsistent use.*

Awareness may be quite high, but that does not mean SDC trust PrEP's efficacy.

In 2017, 3 out of 4 Kenyan SDC were aware of PrEP

However, only 55% of them thought PrEP would work.[4]

Some understand PrEP, but further information is still needed.

The OPTIONS Kenya study found that one in four SDC surveyed understood that taking PrEP can help them reduce their HIV risk.[4] Many agreed that they need further education about how PrEP works.

SDC see a number of benefits—especially emotional benefits—to PrEP.

- **Additional layer of protection.** A 2016 study of SDC in Kenya who had initiated PrEP found that many couples felt safer when using PrEP.[12] It can be seen as a backup to protect them when their partner refuses to wear a condom, in cases of condom breakages, or when the HIV-infected partner is not virally suppressed.
- **Shared commitment as a couple.** Respondents in the 2016 Kenya study also found that using PrEP demonstrates a commitment as a couple to managing the infection and the shared ownership and responsibility.[12]

PrEP use by the uninfected partner can facilitate ART initiation by the infected partner. Some couples found mutual support for adherence when they were both taking HIV medications (one taking for prevention and the other for treatment), fostering an improved sense of caring and openness in the relationship.

> **"Now I will continue with it till it is finished. I just wanted to motivate my wife so that she can (see) that she is not alone. While she takes medicine, I also take…she takes hers and I take mine, we live the way we have been living."[12]** — Uninfected male partner in a serodiscordant relationship, Kenya

- **Reduces stress and preserves relationships.** Similarly, respondents in a Kenya study published in 2016 in the journal AIDS Care often identified relationship-related factors as important reasons to initiate PrEP. For many participants, PrEP was a way to reduce stress within the relationship, for both the infected and uninfected partners. Others felt that PrEP allowed them to preserve their marriages, especially those who viewed HIV prevention as the responsibility of the uninfected partner or as a joint responsibility of both partners.[19]
- **Improved intimacy.** In the 2016 Kenya study, SDC also expressed great optimism and hope that PrEP would help reanimate sex lives and draw couples closer together by reducing or eliminating the need for condoms, which many participants described as diminishing sexual pleasure.[19]

> **"[PrEP] not only protects the HIV-negative partner but also helps many marriages to thrive. In the past, many marriages involving HIV serodiscordant couples collapsed. And another thing, it allows for conception without infecting the partner.[19]** — Female partner in a serodiscordant relationship, Kenya

Overall, the benefit of PrEP is a symbol of hope.

Many SDC see PrEP as a way of resuming a normal life. In one study in Uganda, couples who were experiencing the discordance dilemma said that they saw PrEP as a symbol of hope and opportunity—a means of preserving one partner's health without ending the relationship.[6]

> **"Since we started taking [PrEP] we feel like we have a good future. Earlier on we had seen death."[12]**
> — Female partner in a serodiscordant relationship, Kenya

In another study published in 2016 in AIDS Care, HIV-affected individuals and couples asserted that the provision of safer conception services improved their partnership dynamics by fostering a supportive and respectful environment for them to achieve their reproductive goals.[10]

There is definite interest in using PrEP.

Of SDC surveyed by OPTIONS in Kenya in 2017, 66 percent would use PrEP if given the chance.[4]

SDC also see a number of barriers to using PrEP, especially with the stigma of HIV.[20]

According to in-depth interviews in Kenya, there are real barriers to taking PrEP because of its negative associations. Some people associate PrEP with promiscuity or commercial sex; some study participants who declined PrEP perceived it as a license (potentially for their partners) to increase risky behaviors—an association with "immoral" behavior that explicitly prevented them from initiating PrEP.[20]

In this same study, participants also expressed significant fears around the stigma of HIV that would come from PrEP use,[20] including:

- Fear of being misidentified as HIV-infected (even being seen at an HIV clinic might lead others to this conclusion).
- Fear that pills will be easily mistaken for antiretroviral drugs, more commonly known for HIV treatment.
- Fear of having one's partner's status disclosed.

Additionally, some SDC believed they would need to conceal PrEP use from their partners. This is because they associated PrEP with extramarital affairs, and feared that their partner would assume infidelity was the motivation for their PrEP use.

Other barriers include:

- **Concern over side effects.** Side effects, whether perceived or experienced, were commonly named as potential barriers. Of note, several participants who had initiated PrEP indicated that many of their concerns related to side effects resolved over time with continued PrEP use.
- **Doubts over relative effectiveness of PrEP.** Among participants who declined PrEP, several questioned using it alongside other prevention tools, such as condoms or male circumcision. They viewed PrEP use as duplicating these other prevention tools, particularly condom use.
- **Logistics surrounding PrEP use.** Respondents expressed concerns around daily dosage, size and bitterness of pills, and skepticism over taking a daily pill when not ill. They also described logistical barriers including carrying pills with them and getting to the clinics to get refills.

The 2017 OPTIONS Kenya research found similar concerns among SDC. While side effects are definitely a concern for many respondents, the fear of how they will be perceived by others who discover they are taking PrEP is often of greater worry than any physical or specific drug-related concerns. SDC are also more worried than most that PrEP will result in an increase in sexually transmitted infections, sexually transmitted diseases, and prostitution.[4]

For SDC who take PrEP, there are common barriers to adherence.

In the 2017 OPTIONS research, the most common reasons put forward for a lapse in pill-taking included forgetting, not knowing how it works, being too drunk to remember to take the pills, or PrEP itself being too expensive to purchase every month.[4]

CASE STUDY

Male Partners' Role in Women's PrEP Use

A study in Uganda found greater adherence among women with engaged male partners.

A partner's preferences have a powerful influence on whether a woman uses a product—as well as how she perceives the product herself. Partner disclosure has also been shown to improve acceptability and adherence for PrEP.

A study in Uganda showed that when the male partners were engaged, female participants saw PrEP as a way of improving their lives.[6]

These women went to great lengths to make sure they and/or their partner adhered—such as willingly traveling long distances, under difficult conditions, every month, to keep follow-up appointments and replenish pill supplies. The women even paid for travel in some cases (supplementing the travel stipend provided by the study), showing their serious interest in the opportunity to take PrEP. Women also developed strategies for taking doses correctly, such as setting cellphone alarms or timing their dose to coincide with certain radio programs.

When engaging men in HIV prevention and treatment for SDC, men's specific fears (as drawn from the Uganda study) need to be addressed, including:

- What the community might say about a man who has openly accepted PrEP (for example, that he is "overpowered" by his wife, or is being "herded").
- Being forced to reveal extramarital sexual activity.
- Being forced to have a vasectomy.
- Being laughed at if they accompany their wives to a healthcare center.
- Having to openly discuss sexual matters in front of their wives.
- Being perceived as giving their wives permission to be promiscuous.

**** For more on the importance of engaging men and the barriers created by certain constructions of masculinity, see case study, "Engaging men" in the AGYW audience section.*

How to React and Connect with SDC: Best Channels to Connect

The following details primarily reflect the findings of the 2017 OPTIONS research conducted in Kenya. Except where otherwise noted, the insights listed below are specific to SDC in Kenya; like all insights in this document, these are only a starting point for further investigation focused on a specific audience and context.

SDC' main interests:

Listening to music, watching TV, listening to the radio, spending time with family, going to church, and following the news.[4]

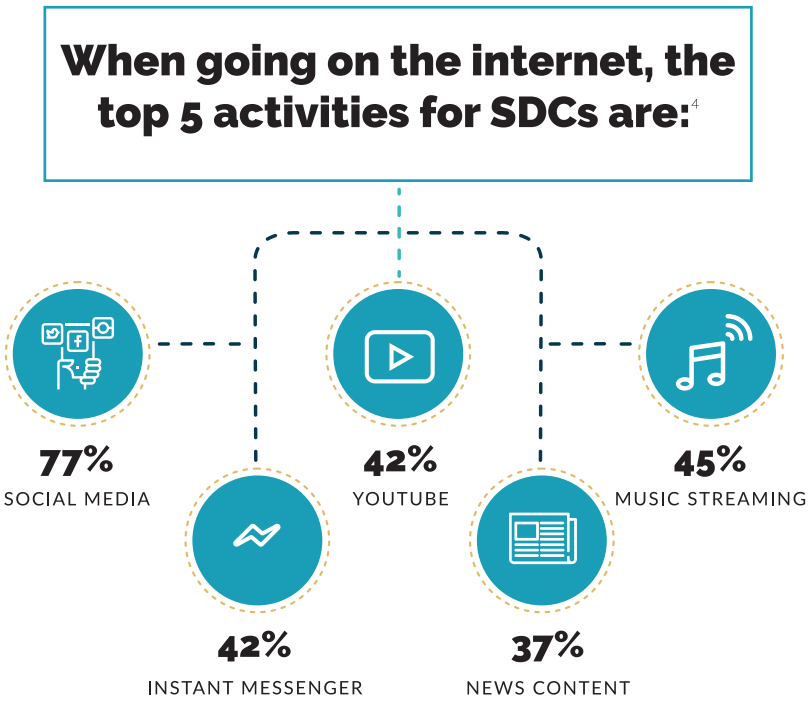
They can be broadly reached through mass media, primarily radio and TV.[4]

Eighty-three percent own a radio and 89 percent own a TV set. The number of radio stations is rising, especially community and FM stations (mostly local-language radio, popularly referred to as "vernacular radio"). They have gained popularity because it is believed that community media directly address the concerns of their audiences.

Newspaper advertising may not be a strong option to reach SDC—even in Kenya, for example, where approximately 3 million people still read a newspaper every day, but printed newspaper circulations are falling or stagnating.

Internet access via smartphone is also popular.

Most people—99 percent—have access to a cellphone; 96 percent of these have their own cellphone, and 66 percent of these have access to a smartphone. People frequently go online, use social media, and instant message through their smartphones (not necessarily a computer—80 percent do not own one).[4]



Gospel music has gone mainstream and could be a way to reach SDC.[21]

Ambiguous lyrics—which can be interpreted as referring to either spiritual or physical love—have helped drive the mainstream appeal of urban gospel in Kenya. From presidential inaugurations to nightclubs, urban gospel is present not just at the periphery, but is now a central attraction and a multimillion-shilling industry; its position at the center of mainstream popular culture is well illustrated by the fact that one condom brand tapped the popular gospel artist Hey Z to be its brand ambassador.

Current and credible sources of sexual health information include radio, TV, and health centers.[4]

SDC also trust doctors and support and counseling groups. Note, however, that SDC do not necessarily trust a recommendation just because it is coming from a healthcare worker.

When asked how they thought PrEP should be communicated to people like themselves in Kenya, SDC primarily recommended radio, TV, and health centers. In almost as high numbers, they recommended seminars, social media, newspapers, talks at church, and through the spouse/partner.

How to Reach and Connect with SDC: Best Tactics to Connect

Couple HIV counseling is an important strategy for SDC.[4]

Counseling both partners at the same time may be more effective in reducing risk behaviors than counseling partners individually.[22]

Couple counseling either immediately following testing or at a later date may encourage SDC to initiate HIV treatment as prevention as well as PrEP. Evidence from different sub-Saharan African countries also confirms that couple HIV counseling can be effective in increasing condom use among SDC. Additionally, when partners agree to take responsibility for their HIV status together, challenges related to stigma, violence, divorce, and abandonment can be addressed through the counseling session.

Many SDC are highly interested in conceiving, which is an important motivator for PrEP.

According to the South Africa PrEP National Guidelines from 2016, the use of PrEP around the time of conception and during pregnancy offers a means of protection to the uninfected partner.[3] Many SDC place a high priority on conceiving children; emphasizing PrEP as a way to conceive safely may thus be an important route to uptake and adherence.

Reaching SDC through family planning and fertility services may be an effective tactic.

Creating outreach strategies that offer counseling on sexual and reproductive health services, including fertility, may be a valuable way to engage SDC around a topic of high interest. In this context, information about PrEP may be introduced in a way that explicitly connects HIV prevention to couples' priorities and goals.

To engage both partners in an SDC, it may be necessary to explicitly reach out to men in non-clinic spaces, which are considered more "masculine." Places to reach men may include:[23]

- Male educators traveling door to door to disseminate information specifically for men.
- Male outreach programs, as these workers are viewed as more trustworthy.
- Men's *barazas* (community meetings held by village leaders).
- Churches.
- Schools.
- Funerals.
- Microfinance groups.
- Football matches.

Whenever possible, have existing PrEP users discuss the decision to use PrEP.

A study in Kenya showed that early PrEP-use experiences reinforced the decision to use PrEP. Thus, having early PrEP adopters work alongside health providers in PrEP delivery programs may increase initiation and continuation of PrEP.[12]

How to Reach and Connect with SDC: To Keep in Mind for Engagement in Sexual and Reproductive Health and HIV Testing, Prevention, and Treatment

Consider support services for newly identified SDC; couples will benefit from support, including the offering of PrEP immediately after testing and identification of discordance.

SDC have a range of needs that emerge after the initial couple counseling and testing session; addressing these needs is critical to ongoing prevention and treatment.[8]

How to Reach and Connect with SDC: To Keep in Mind for Communicating PrEP

Offer clear information about times when SDC should use condoms.

Because of the enthusiasm some SDC expressed for PrEP as a replacement for condoms, it is important to provide clear messaging about how condoms can still play an important role for preventing sexually transmitted infection transmission and as a backup in case PrEP is not taken consistently.[5] Because research shows that seven days of daily dosing is needed to reach adequate tissue levels of PrEP drugs, it is important that SDC understand that condoms must be used during this seven-day period for protection against HIV transmission.[24]

PrEP can be used in combination with ART.

Suppressing the infected partner's viral load with the consistent and correct use of ART reduces sexual transmission by 96 percent; the uninfected partner's consistent and correct use of PrEP may reduce sexual transmission by as much as 75 percent.[25] Therefore, to effectively reduce HIV infection among SDC, it is recommended that the HIV-positive partner should be initiated on ART regardless of CD4 count while the HIV-negative partner uses PrEP at least until viral suppression is achieved by the infected partner.[3]

PrEP can be used during pregnancy.

The World Health Organization is doing additional research on the benefits and risks of PrEP in pregnancy and has recently released the following statement:

"Although additional surveillance is important, at the present time, given the available safety data, there does not appear to be a safety-related rationale for discontinuing PrEP during pregnancy and breastfeeding for HIV-uninfected women receiving PrEP who become pregnant and remain at continuing risk of HIV acquisition."[1]

The research for the SDC profile was based largely on three studies—one in Kenya (OPTIONS 2018), one in Tanzania (Ngilangwe 2015) and one global meta-analysis looking at the risk of HIV transmission per heterosexual act (Boily 2009). The meta-analysis included 43 publications from 25 different observational studies conducted around the world. The OPTIONS Kenya market intelligence report included interviews of 101 individuals (male and female, seropositive and seronegative) whereas in Tanzania, 1,333 couples were interviewed. The Tanzania research was conducted between 2005 and 2007, while the Kenya research was conducted in 2017. The mean age of participants from Kenya was 35.9 and in Tanzania was 32.

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