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Executive Summary
Technical Summit on Women, HIV, and Violence
February 13-14, 2014

On February 13 and 14, 2014, AIDS United, with the generous support of AbbVie, convened an interdisciplinary group of activists, thought leaders, academics and federal partners to review and respond to the report issued by the President's Federal Interagency Working Group on the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities. Released in September 2013, the report identified five objectives and recommended actions for federal agencies to increase interventions to not only link women living with HIV and affected by violence to much needed services and care, but to also ensure retention in care, provide support, as well as encourage broader prevention efforts and research. The Summit was convened to provide commentary and develop innovative community-driven advocacy and implementation strategies to address the intersection of women, HIV and violence with key input from diverse experts, including women living with HIV.

Addressing Trauma: A Remarkable Opportunity

It is increasingly recognized that trauma – childhood and adult physical, emotional and sexual abuse, neglect, loss, and community violence – is associated with the leading causes of morbidity, mortality, and disability in the United States, especially for vulnerable populations of women. Women living with HIV experience disproportionate rates of trauma and post-traumatic stress disorder (PTSD) compared to the general population of women: 55% have experienced intimate partner violence (IPV), twice the national rate; over 60% have been sexually abused, five times the national rate; and 30% have PTSD, six times the national rate.[1] Finally, trauma and PTSD are associated with poor health outcomes at each state of the HIV care continuum, including disengagement from care and non-adherence to treatment and care that can result in medication failure, viral rebound, or delay achievement of viral suppression. Recent trauma is also linked with almost twice the rate of death among HIV-positive women.[2]

The Summit: A Community-Driven Response

Through presentations by community and federal leaders, small working group sessions and large group discussions, Summit participants developed action plans focused on three specific recommendations provided by the President's Interagency Working Group report:

1. Increase IPV screening and HIV testing for girls and women and encourage concurrent screening;
2. Screen women living with HIV for IPV and link them to appropriate services; and
3. Develop, implement, and evaluate models that integrate trauma-informed care into services for women living with HIV.

These action plans included four critical pieces: community implementation action steps or local advocacy needed to operationalize each recommendation; tasks and activities needed to carry out each action step; resources required; and critical stakeholders to engage. Participants worked in small groups to develop action plans for each of the above recommendations and emphasized two action steps most critical to advancing the larger issue of women, HIV and violence.

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[1] Machtinger, E.L., et al. Psychological trauma and PTSD in HIV-positive women: a meta-analysis. *AIDS Behavior*. 2012; 16(8): 2091-2100.

[2] Interagency Federal Working Group Report. *Addressing the Intersection of HIV/AIDS, Violence against Women and Girls, & Gender–Related Health Disparities*. Available at: http://www.whitehouse.gov/sites/default/files/docs/vaw_master_report.pdf.

Increase IPV screening and HIV testing for girls and women and encourage concurrent screening.

1. Encourage concurrent screening by convening or building upon local- or state-level interagency working groups, and placing the issue of women, HIV and IPV in the context of health care reform; and
2. Develop templates for workshops and webinars for providers and clinic staff to ensure increased awareness of and screening for IPV in this setting.

Screen women living with HIV for IPV and link them to appropriate services.

1. Participate in federal advocacy across departments to integrate IPV screening into existing practices, including Centers for Disease Control and Prevention (CDC) testing guidelines, Health and Human Services (HHS) HIV testing guidelines, Health Resources and Services Administration (HRSA) case management and clinician trainings and Substance Abuse and Mental Health Services Administration (SAMHSA) guidance. Work also with the Housing Opportunities for Persons with AIDS (HOPWA) Program to prioritize housing (emergency and long-term) for HIV-positive women in violent situations; and
2. Drawing from models and interventions that already exist, develop best practices for the integration of HIV and domestic violence linkage and bring to scale.

Develop, implement and evaluate models and integrate trauma-informed care into services for women living with HIV.

1. Put out a call to develop, coordinate and implement trauma-informed care projects, subject to rigorous evaluation, which are tied to advancing the continuum of care and patient outcomes. These projects should be built on local community collaboratives that engage clinics, HIV- and domestic violence-related community based organizations, law enforcement officials, local elected officials and others to ensure that services provided are culturally competent and cut across disciplines and stakeholders; and
2. Influence policy at the national, state, local, and tribal levels by ensuring the issue of women, HIV and violence is included in relevant policy documents and opportunities, and that key entities are aware of our priorities and are engaged as collaborators.

Next Steps

The interdisciplinary nature of the Summit allowed for robust conversation, new partnerships and the promise of projects that could alter the current landscape of women, HIV and violence in the United States. Disseminating the action steps and community-based strategies developed during the Summit is critical to this work, and possibilities for accomplishing this include:

1. Hosting a Congressional Briefing to educate Members of Congress , their staff, and to highlight Congressional champions;
2. Developing a best practices compendium on innovative models that integrate HIV and IPV work;
3. Partnering with entities working in related spheres, including the broader reproductive health field and funders engaging in similar work; and
4. Continuing engagement and partnerships with domestic violence stakeholders and federal partners through webinars, community blogs and other media-related outreach opportunities.

Optimizing health outcomes for HIV-positive women requires us to recognize the role of violence and related trauma that so clearly impacts women's abilities to access and remain engaged in care. Ultimately, we must address the issues of HIV and violence together if we are to tackle women's health as a whole.

AIDS United Technical Summit on Women, Violence and HIV

Meeting Summary

Sofitel Hotel, Washington, DC

February 13-14, 2014

Acknowledgements

AIDS United would like to thank all of the invited participants to the Technical Summit. Due to an unexpected weather system that resulted in hundreds of canceled flights into Washington, DC as well as a mandatory closing of the federal government based on the same weather system, many of the confirmed participants could not participate in the Summit. Thus, the information synthesized in this report is reflective of a subset of the participants that were able to be present at the Technical Summit (noted in Appendix A). Those pictured above were present on both days, and participated in all activities. Back row (from left to right): Liz Hanpeter, Eddy Machtinger, Jackie Campbell, Jessica Terlikowski, Liz Brosnan, Kat Griffith, Olivia Ford, Linda Scruggs. Middle row (from left to right): Dazon Dixon-Diallo, Naina Khanna, Maggie Czarnogorski, Heidi Nass, Stephanie Cruse, Maura Riordan, Catherine Ferguson. Seated row (from left to right): Vanessa Johnson, Kathie Hiers, Donna Crews, Vignetta Charles. A special thanks to AbbVie for their generous support in sponsoring the Summit.

Introduction

AIDS United is a national HIV/AIDS grant making and policy organization whose mission is to end AIDS in the United States. The work of AIDS United (AU) is strategically aligned with both the National HIV/AIDS Strategy and within the framework of the HIV Care Continuum established by the Obama Administration in its effort to increase access and retention in care, reduce health disparities, and prevent new HIV infections in the US. Alignment with critical federal strategies allows AIDS United to identify where private philanthropic dollars, federal, regional, and local advocacy strategies, and public-private partnerships may provide complementary efforts to address gaps in, or partner with, strategic federal efforts.

In March 2012, a Presidential Memorandum issued a call for the formation of an Interagency Federal Working Group on Addressing the Intersection of HIV/AIDS, Violence Against Women and Girls, and Gender-Related Health Disparities. The creation of the Working Group represented a tipping point in our country's awareness that unaddressed trauma fuels every aspect of the HIV epidemic among women - from predisposing women's risk for acquiring HIV to negatively affecting their health outcomes at every stage of the HIV care continuum. The release of the Working Group's report in September 2013 represents a historic national commitment to addressing trauma as a means to reduce new HIV infections and improve health outcomes for women living with HIV. The report identifies five objectives and recommended actions for federal agencies to increase interventions to link women living with HIV and affected by violence to much-needed services and care, as well as encourages broader prevention efforts and research. AIDS United realized that identifying complementary and innovative community-driven advocacy and implementation strategies to address the intersection of women, HIV and violence would augment the strategies of the Working Group.

In addition to the Working Group's report, the evidence base that helped catalyze AIDS United's urgency in response includes:

- Women living with HIV experience highly disproportionate rates of trauma and post-traumatic stress disorder (PTSD) compared to the general population of women: 55% have experienced intimate partner violence (IPV), twice the national rate (the Positive Women's Network USA found in a survey of their membership that 72% of women respondents identified themselves as survivors of intimate partner violence[3]); over 60% have been sexually abused, five times the national rate; 30% have PTSD, six times the national rate;[4]
- Both trauma and resultant PTSD are associated with increased risk of HIV infection;[5] and
- Trauma and PTSD are associated with poor health outcomes at each stage of the HIV care cascade, including disengagement from care, medication non-adherence and medication failure. Recent trauma is also linked with almost twice the rate of death among HIV-positive women.[6]

An additional motivation to respond to addressing this intersection of violence and HIV among women at-risk for, and living, with HIV is that it has implications for many other populations affected by high rates of unaddressed trauma.

On February 13 and 14, 2014, AIDS United, with the generous support of AbbVie, convened an interdisciplinary group of activists, thought leaders, academics and federal partners to review and respond to the Working Group's report. Although the report is a tremendous accomplishment in providing a roadmap for federal agencies, the goal of the Technical Summit was to provide an opportunity to focus on the best strategies for operationalizing the recommendations at a community level and identifying advocacy strategies to advance these efforts. As one federal stakeholder said, the community must "breathe life" into the report in a push toward community implementation of the recommendations.

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[3] Khanna, Naina. "Addressing Trauma to Improve the Continuum of Care for Women Living with HIV." PowerPoint presentation. Sofitel Hotel, Washington, DC. 13 Feb 2014.

[4] Machtinger, E.L., et al. Psychological trauma and PTSD in HIV-positive women: a meta-analysis. *AIDS Behavior*. 2012; 16(8): 2091-2100.

[5] Ibid.

[6] Interagency Federal Working Group Report. *Addressing the Intersection of HIV/AIDS, Violence against Women and Girls, & Gender–Related Health Disparities*. Available at: http://www.whitehouse.gov/sites/default/files/docs/vaw_master_report.pdf.

This Technical Summit meeting summary outlines the process used to solicit input at the Technical Summit, as well as summarizes the recommendations for action steps.

Glossary of Definitions and Acronyms

It is important to note that several terms are mentioned throughout this report that require clarity on definitions. Given the focus on the meeting, all terms are mentioned within the context of violence against women and girls. Below are definitions and acronyms taken from expert presentations throughout the Summit.

DV: Domestic Violence:

> A pattern of coercive, controlling behavior that can include physical abuse, emotional or psychological abuse, sexual abuse or financial abuse (using money and financial tools to exert control) (National Network to End Domestic Violence).

IPV: Intimate Partner Violence:

> Violence perpetrated by a current or former boyfriend, cohabiting partner, husband, or date. This includes, but is not limited to, physical violence, sexual violence, stalking, control of reproductive or sexual health, aggressive/coercive tactics, and emotional abuse (Centers for Disease Control and Prevention).
>
> *Note: Participants at the Summit noted that this definition placed emphasis on males as perpetrators. Although this was a baseline working definition, discussion at the Summit acknowledged that perpetrators are not always male and this definition was modified in discussion.*

PTSD: Post-Traumatic Stress Disorder:

> PTSD develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers. PTSD can result from a variety of traumatic incidents, such as war, mugging, rape, torture, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters such as floods or earthquakes (National Institute of Mental Health).

Trauma:

> Resulting from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. Events and circumstances include, but are not limited to, physical, emotional and sexual abuse; neglect; loss; and community violence in childhood and/or adulthood (Substance Abuse and Mental Health Services Administration).

ACA: Patient Protection and Affordable Care Act

AU: AIDS United

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CME: Continuing Medical Education

DHHS/HHS: U.S. Department of Health and Human Services

HOPWA: Housing Opportunities for Persons with AIDS

HRSA: Health Resources and Services Administration

HUD: U.S. Department of Housing and Urban Development

MSM: Men Who Have Sex with Men

NASTAD: National Alliance of State and Territorial AIDS Directors

NCHHSTP: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

NIH: National Institutes of Health

NNEDV: National Network to End Domestic Violence

OAR: Office of AIDS Research

ODPHP: Office of Disease Prevention and Health Promotion

OWH: Office on Women's Health

PACHA: Presidential Advisory Council on HIV/AIDS

PLHIV: People Living with HIV

SAMHSA: Substance Abuse and Mental Health Services Administration

VAW: Violence against Women

Planning the Summit

A planning committee (noted in Appendix A) was formed to ensure a comprehensive, but succinct agenda, as well as to identify critical stakeholders to invite as participants. Planning committee members included academics, clinicians, community advocates, AIDS United staff, and Federal Interagency Working Group members. Although there are many individuals who could contribute substantively to the Summit, the planning committee elected to make the Summit small to ensure depth of conversation. Thus, the committee had the difficult task of limiting invitations to 25 participants.

The planning committee determined via consensus that the best use of the Summit would be to focus on only a few of the Working Group recommendations. These recommendations included the following:

1. Increase IPV screening and HIV testing for girls and women and encourage concurrent screening (Recommendation 1.1 from the Working Group report);
2. Screen women living with HIV for IPV and link them to appropriate services (Recommendation 2.1 from the Working Group report); and
3. Develop, implement, and evaluate models that integrate trauma-informed care into services for women living with HIV (Recommendation 2.2 from the Working Group report).

The planning committee also determined that this Summit could coincide with a "relaunch" of the Working Group report at the White House. This opportunity to link the Technical Summit with a White House event highlighting the Working Group and the need for complementary strategies to the report solidified the desire to link the work of the federal partners to community strategies. There was a deliberate overlap between participants in the Summit and the White House relaunch of the Working Group report. In addition, the agenda for the Summit was tailored to accommodate full attendance of the Summit participants in the White House event.

Summit Process for Soliciting Recommendations

The Summit was facilitated by AIDS United's Vice President of Access and Innovation, Maura Riordan. The agenda included four stages: (1) Expert presentations to lay the groundwork; (2) Small group breakouts to delve deep into the recommendations highlighted above and identify community-driven advocacy and innovative programmatic strategies; (3) Attendance at the White House relaunch of the report; and (4) Large group reactions to the small group action steps. The complete agenda is appended to this report (Appendix B).

Laying the Groundwork: Expert Presentations

The meeting began with presentations from a panel of experts on the topics of women, violence and HIV. The goal of these presentations was to provide a level-setting introduction for a diverse group of participants. This was accomplished by carefully selecting speakers that would provide not only the most up-to-date information from their respective fields, but to also provide expert perspective on the needs around this critical intersection. Speakers and their presentation titles included the following:

- Francis Ashe-Goins, RN, MPH, Associate Director, US-DHHS-OWH *: Addressing the Intersection of HIV/AIDS, Violence Against Women & Girls, and Gender-Related Health Disparities – Interagency Federal Work Group Report;*
- Gina Brown, MD, Medical Officer, Office of AIDS Research (OAR), National Institutes of Health (NIH), U.S. Department of Health and Human Services (HHS): *Violence Against Women and HIV Risk;* and
- Naina Khanna, Executive Director, Positive Women's Network USA, & Eddy Machtinger, MD, Director of Women's HIV Program, University of California, San Francisco (UCSF): *Addressing Trauma to Improve the Care Continuum for Women Living with HIV.*

These speakers shared information on: (a) The Federal Interagency Working Group findings; (b) Broader research findings on the evidence base about women, violence, and HIV; and (c) A model of trauma-informed primary care that could address disproportionately poor health outcomes among HIV-positive women that have experienced trauma. Key points shared by panelists included:

- **The link between sexual violence and biological HIV risk**: New ways of thinking about VAW were a key part of Dr. Brown's presentation. A more nuanced biological understanding of sexual violence and increased HIV infection is emerging. Tears in genital mucosa due to sexual violence may produce an altered inflammatory response and create prolonged alterations in genital tract immune function, leaving women more vulnerable to HIV infection;
- **Engaging HIV+ Women in Traditional Care Still May Not Save Their Lives**: At the University of California San Francisco (UCSF) Women's HIV Program, the majority of recent deaths were women who were already engaged in care; of the nine most recent deaths, eight of the women had undetectable viral loads. In attempts to solve this puzzle, the team at UCSF realized what the program was missing were the skills and interventions to help women heal from the cumulative effects of trauma. Commonalities among these women were stigma, nondisclosure, isolation, depression, substance abuse, and histories of neglect and trauma. Up to that point, no one in the field had assembled a model of trauma-informed primary care that addressed past abuse and healing. The UCSF team realized that adherence to treatment and doctor's visits was not enough, but that a different model of care was necessary to heal women holistically in order to save their lives; and
- **Introducing a Conceptual Model of Trauma-Informed Primary Care**: A conceptual model of trauma-informed primary care was introduced by Dr. Machtinger and Naina Khanna at the Summit. The model presents a holistic approach that has three components: (1) Environment (calm, safe, empowering for both patients and staff); (2) Screening (inquiry about current and lifelong abuse, PTSD, depression and substance use; patient-led disclosure); and (3) Response (onsite and community-based programs that promote safety and healing; recent trauma would be responded to algorithmically, while lifelong trauma would be responded to with trauma-informed practices built into existing systems of care). Trauma-informed primary care must be built on a foundation of trauma-informed values, robust partnerships, clinic champions, support for providers, and ongoing feedback and evaluation. This is a model not just for women living with HIV; it can also benefit other people living with HIV (PLHIV), including black men who have sex with men (MSM) and transgender women of color, as well as the large number of people without HIV who experience poor health outcomes related to trauma. A model of trauma-informed primary care based on these values is more directly aligned with the healing process.

The large group discussion that followed the panel presentations was rich and robust, and fell into three main themes:

I. <u>Framing a Trauma-Informed Care Approach</u>

All personnel are trained in trauma-informed approaches. In addition to trainings on trauma-informed care for physicians and caregivers, it is imperative for front desk staff, pharmacists, and other personnel who interact with patients on a regular basis to receive the same training. A woman may feel more comfortable disclosing a trauma to personnel other than her doctor, and it is crucial that staff are able to respond to those opportunities to address trauma;

Recognizing trauma symptoms while simultaneously moving women across the care continuum towards viral suppression. In a traditional scenario, a woman living with HIV may drop out of care due to symptoms of trauma that go unrecognized in a clinical setting, and is considered "non-adherent" with treatment and care. A trauma-informed care approach can recognize and address this critical context while retaining women in order that they benefit fully from effective HIV medical care;

Changing the primary care culture for the provider. Within the current primary care model, it is difficult for a provider to be in a space to think about actually helping people heal. A clinical environment that is often attempting to provide medical care within an overburdened system can run counter to the needs of patients who have experienced trauma and for clinicians who want to provide a model of care that meets these needs; and

Improving screening tools. Advances in screening are critically needed, but must also be accompanied by in-depth trainings on best practices for those who will carry out the screenings. Many clinical settings are not screening for trauma, or are not doing so in a way that makes it likely that a woman will disclose critical information that can impact her care and health trajectory.

II. <u>Addressing Complex Dynamics and Safety in Relationships</u>

Dynamics within abusive relationships are dangerous, but can also be complex and must be responded to with this in mind. It is important to acknowledge the love that a person may have for a perpetrator while also helping them assure their own safety. Some women may not recognize violence in their own lives – violence has become so normalized, so intimate and engrained in everyday lives, and current screenings do not adequately address this point;

It is critical that we create interventions for individuals who are initiating violence. If we are to make significant and sustainable changes concerning violence against women, cultural/social changes must happen. Men and women in powerful positions need to be role models for other men in the discourse on VAW; and

Economic empowerment is important to women's survival and should not be underestimated as it relates directly to violence and risk for HIV. Strategies for assisting women to leave violent relationships while maintaining economic independence is a critical issue.

III. Bridging the Gap Between Care and Messaging/Advocacy

Complex but accurate messaging around non-occupational post-exposure prophylaxis (nPEP) guidelines for women is needed if nPEP is to be a useful tool in helping women who have experienced sexual violence maintain an HIV negative sero-status;

Additionally, there is **a need for outcome data for women given nPEP** in emergency rooms if we are to understand its effectiveness for women. The CDC is currently in the process of updating its nPEP guidelines, which means this a timely issue. Stakeholders should think critically about the role NIH can have on this issue. A better understanding of the existing data around nPEP usage is important. Furthermore, there are no guidelines, no implementation, no strategy, and no data on nPEP usage in some states; and

There should be a greater emphasis on IPV within NIH treatment guidelines as well as within Healthy People, which means greater engagement is needed with the Office of Disease Prevention and Health Promotion (ODPHP) at HHS.

Small Group Breakouts

Following the large group discussion, Summit participants were assigned to small groups comprised of a combination of federal partners, academics, and community advocates in each group to ensure diversity of perspective within each group and asked to focus on one of three key recommendations in the Working Group report. Members in each group were tasked with providing their top two suggestions within the corresponding recommendation. With an eye towards creating a community implementation plan, the groups needed to consider the tasks/activities necessary to complete the recommendation, resources needed, and stakeholders to engage. Below are the full recommendations from each group at the Summit.

Group 1: Increase IPV screening and HIV testing for girls and women and encourage concurrent screening.

Encourage concurrent screening of IPV and HIV, and integrate this practice into the new and evolving Affordable Care Act (ACA)-driven systems:

- Identify local community-based organizations (CBO's) to facilitate community meetings, inviting state and local stakeholders and thought leaders;
- Ensure that stakeholders and providers have a working knowledge of state Essential Health Benefits, IPV screening and the prerequisite training needed to carry out this screening;
- Highlight health jurisdictions where successful models and best practices are occurring;
- Engage local health officials in meetings and education opportunities;
- Identify a champion at the health department level (state or local) as well as an elected official who can serve as a champion; and
- Create an advocacy toolkit that can be used by community members to bring violence and trauma-informed models of screening, linkage and care into their communities.

Advocate for HRSA support and Ryan White Program reauthorization:

- Develop messaging focused on health and healing beyond medication treatment and adherence;
- Utilize trained peers as skilled navigators and role models in surviving violence and trauma, and train and utilize Community Health Workers in understanding a trauma-informed model of linkage and care;
- Identify key champions in communities and on Capitol Hill to join HRSA/Ryan White conversations; and
- Integrate training components on the intersection of women, violence and HIV into AETC training curricula with Ryan White Program providers.

Get buy-in from the diverse range of national HIV/AIDS and allied partner organizations in educating and supporting models of care that are violence and trauma-informed:

- Including, but not limited to: National Minority AIDS Council, AIDS United Public Policy Committee, Southern AIDS Coalition, National Coalition of STD Directors, and National Association of State & Territorial AIDS Directors.

Engage allied national professional associations in advocacy and education on the intersection of women, HIV and violence:

- Target professional associations (*including associations for social workers, nurses, and doctors*) and educate them on the link between IPV and HIV, and the critical role of screening;
- Identify champions within these groups to assist with advocacy and education efforts; and
- Create a template for workshops and webinars for professional associations, taking CME requirements into consideration in order to maximize impact and participation.

Make IPV a quality of life metric in Medicaid:

- Begin dialogue by extending letters of invitation to Centers for Medicare and Medicaid Services (CMS) representatives to engage in meetings; and
- Approach Congressional champions who are members of the Women's Caucus to enlist their leadership.

Develop a curriculum of best practices available for providers on IPV screenings and develop a toolkit that can be distributed to clinics;

Conduct a cost benefit analysis of concurrent HIV and IPV screening and brief interventions based on best practices; and

Request an Institute of Medicine report with a focus on data collection on the scope of the problem and clinical best practices in place, and use report findings for ongoing advocacy efforts.

Group 2: Screen women living with HIV for IPV and link them to appropriate services.

Reinvigorate and build upon the work of the National Network to End Domestic Violence (NNEDV):

- Rather than creating something from the ground up, review existing IPV trainings and identify areas of integration for HIV. For example, NNEDV has developed an IPV training integrated with HIV, which is currently in its pilot phase. Once the training has been piloted, follow up and re-engage with trainers to get their feedback on challenges, successes, and to identify necessary revisions. Once a curriculum is finalized, marketing for optimal dissemination will need to take place. A specific training module should be developed for IPV-prevention interventions to link HIV-positive women into appropriate programs. Efforts to introduce this curriculum into the domestic violence field will be necessary. Resources will be required to engage stakeholders, and implement and evaluate the curriculum.

Integrate IPV screening into CDC testing guidelines:

- Seek input from HIV and IPV communities to inform the development of language around integrated testing guidelines;

- Draft recommended language for the integration of IPV screening into CDC testing guidelines and advocate for this change at the federal and state levels;
- Present the request for IPV screening integration to the Director of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) while concurrently advocating for integrated screening at the state level; and
- Recruit watchdog organizations to assist with ongoing monitoring of implementations and enforcement (for example, Presidential Advisory Council on HIV/AIDS [PACHA], networks of HIV-positive individuals and organizations, as well as DV organizations).

Secure HRSA guidance that includes IPV screening in case management and clinician trainings:

- Review and evaluate existing content and language on IPV screening, and modify for inclusion of HIV co-screening; and
- Organized advocacy at the federal level will be needed, including meetings with the Associate Administrator for the HIV/AIDS Bureau at HRSA.

Integrate IPV screening into SAMHSA guidance on screening for mental health for PLWHA:

- Review and evaluate existing guidelines and find areas for IPV/HIV integration; and
- Meet with HIV/AIDS Policy lead at SAMHSA to recommend proposed modifications and discuss how to implement screening integration.

Propose prioritization of Housing Opportunities for People with AIDS (HOPWA) resources for women living with HIV who are in violent situations:

- Review and evaluate existing guidelines and propose revisions where appropriate; and
- Meet with Director, Office of Special Needs Assistance Programs at HUD, and Acting Director, Office of HIV/AIDS Housing, HUD.

Work with faith-based institutions and progressive HIV/DV-focused ministries as points of education and intervention in local communities:

- Facilitate cross training between DV and HIV ministries within local churches.

Create a common language between HIV and DV communities to address chasm framing:

- Begin a process for the DV and HIV communities to dialogue and come to a shared understanding of the group values in the DV and HIV communities. Currently, the HIV and DV communities utilize different framing language, which may be interpreted as oppositional. For example, a woman who has experienced violence in the DV community may be referred to as a "victim", whereas that specific language is frowned upon in the HIV community, where agency and empowerment are key elements in framing issues; and
- Develop of a set of principles that convey HIV and DV priorities and values could help build a more effective advocacy partnership, including the awareness and commitment to addressing intersecting issues together in a culturally competent manner. This will inform future curriculum, education and training efforts.

Develop best practices for integration of HIV and IPV linkage and bring to scale.

Group 3: Develop, implement, and evaluate models that integrate trauma-informed care into services for women living with HIV.

The overarching principles in approaching the integration of trauma-informed care into services for women living with HIV/AIDS are: 1) Frame everything in the context of the care continuum and improving patient outcomes; 2) Ensure HIV-positive women are involved in all tasks and activities; and 3) Cultural competency is critical in developing services based on each local community and its particular needs.

Pilot 2-3 local Community Leadership Teams as a model of community planning and implementation:

- Identify a small core group of community stakeholder to form a leadership team; this may include leaders from the local clinic, CBO, or health department; and
- Once leadership teams are formed, teams will begin resource mapping to find local strengths and champions to align with in advocacy efforts and systems change. Identify champions (including policy makers and elected officials) and mentors. Mentors may include individuals who are involved in best practice models locally or elsewhere. Next, the establishment of common values, principles and definitions will be critical to group cohesion and effectiveness. Once this core group is established, bringing in new representatives from the local hospital emergency room, law enforcement allies, churches, and others will help increase community buy-in, reach and commitment.

Create coordinated implementation and evaluation of trauma-informed care projects tied to advancing continuum of care and patient outcomes:

- On the local level, steps should be taken to ensure that the packages of services are in place prior to screening;
- Ensure that these projects utilize existing evidence-based strategies that are synergistic with other similar projects focused on HIV and IPV; and
- National funding and coordination will be required to resource this critical effort. The following groups should be engaged in efforts to move projects forward: OWH, HRSA, SAMHSA, OAR, Office of Technology, Positive Women's Network USA, the Congressional HIV and Women's Caucuses, Office of HIV Prevention, NASTAD, NNEDV, and National Association of County Health Officers.

Influence policy by inserting the intersection of women, violence and HIV and minimum requirements for launching trauma-informed care into upcoming policy documents and opportunities (NHAS if extended, Healthy People, and Ryan White Program):

- Start articulating priorities with key messages and talking points for federal stakeholders now; and
- Leverage impact in policy by collaborating with experts from intersecting issues and fields. This messaging can come from a variety of stakeholders: Researchers, storytellers, PWN-USA members, AIDS United, HIV Medical Association, Federal AIDS Policy Partnership, domestic violence policy experts, sexual and reproductive health experts, Congressional HIV and Women's Caucuses.

Develop an inventory of innovative practices that can be used to address a trauma-informed response in communities:

- This effort will call for a research-led team to collect and analyze data. Resources will have to be secured for this, whether from federal or private sources.

Final Recommendations

Although the action plans for each of the groups were far more exhaustive (as seen above), the Working Group recommendations and corresponding top priorities from Summit participants are listed below:

Increase IPV screening and HIV testing for girls and women and encourage concurrent screening.

1. Encourage concurrent screening by convening or building upon local- or state-level interagency working groups, and placing the issue of women, HIV and IPV in the context of health care reform; and

2. Develop templates for workshops and webinars for providers and clinic staff to ensure increased awareness of and screening for IPV in this setting. Ensure AETCs are asked to develop and disseminate training materials.

Screen women living with HIV for IPV and link them to appropriate services.

1. Participate in federal advocacy across departments to integrate IPV screening into existing practices, including Centers for Disease Control and Prevention (CDC) testing guidelines, Health and Human Services (HHS) HIV testing

guidelines, Health Resources and Services Administration (HRSA) case management and clinician trainings and Substance Abuse and Mental Health Services Administration (SAMHSA) guidance. Work also with the Housing Opportunities for Persons with AIDS (HOPWA) Program to prioritize housing (emergency and long-term) for HIV-positive women in violent situations; and

2. Drawing from models and interventions that already exist, develop best practices for the integration of HIV and IPV linkage and bring to scale.

Develop, implement and evaluate models and integrate trauma-informed care into services for women living with HIV.

1. Put out a call to develop, coordinate and implement trauma-informed care projects, subject to rigorous evaluation, which are tied to advancing the continuum of care and patient outcomes. These projects should be built on local community collaboratives that engage clinics, HIV- and domestic violence-related community-based organizations, law enforcement officials, local elected officials and others to ensure that services provided are culturally competent and cut across disciplines and stakeholders; and

2. Influence policy at the national level by ensuring the intersection of women, HIV and violence is included in relevant policy documents and opportunities, and that federal entities are aware of our priorities and are recognized as collaborators.

The participants developed an extensive list of dissemination strategies for the outcomes of the Summit, with a focus on sharing the community-level recommendations with policy makers and advocates across the United States.

Conclusion:

There is a growing awareness within the field of HIV/AIDS regarding the clear relationship between women and girls, HIV/AIDS, and violence. The Working Group has provided a framework for federal mobilization in responding to this intersectional issue. However, a complementary and vital community response and partnership in implementing recommendations, will be necessary in order to "breathe life into the report," as one expert noted. The Technical Summit provided an opportunity for cross-sector discussion and the exchange of information. Within a two-day meeting, a remarkable amount of work was done to forge a path toward community implementation of the Working Group report. There are both significant opportunities at hand to impact the trajectory of the continuum of care for women living with HIV in the United States, but also formidable challenges in implementing a scalable response to the violence and trauma they have disproportionately experienced and which continue to negatively impact their health outcomes.

A two-pronged strategy must be taken in order to develop "best practices" to best serve women at-risk for and living with HIV who have experienced violence:

- A strategic advocacy plan that focuses on creating opportunities for better coordination and resourcing of best practices at federal and state levels; and
- Scaling best practices in localities, which will require dissemination of key evidence, mentoring, and the sharing of successful strategies.

The implication for this work extends far beyond women at risk for, and living with HIV. Developing best practices will inform similar efforts among other vulnerable populations including gay minority youth and transgender women. Emerging evidence points to violence and trauma as fueling the poor outcomes across the care continuum. Our ability to effectively address this reality in communities, alongside breakthroughs in biomedical tools, will go a long way in ending the HIV/AIDS epidemic in the US. AIDS United will continue to expand innovative partnerships with public agencies, community advocates, and academics to provide the HIV/AIDS community with strategies to overcome this intersectional barrier to ending the epidemic.

Appendix A: Participant List with notations for any limitations on attendance and Planning Committee Participation

Women, Violence & HIV Summit
February 13-14, 2014
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Appendix B: Agenda

Technical Summit on

Women, HIV and Violence

Dates	Location
Thursday, February 13th to	**Sofitel Hotel**
Friday, February 14th, 2014	**Washington, DC**

AGENDA

Summit Objectives

- ⇒ Provide thorough review and response to the President's Working Group's report
- ⇒ Solicit recommendations for community-driven strategies to address the intersection of women, HIV, and violence

THURSDAY, FEBRUARY 13TH

Time	Activity	Location
8:00 – 8:30am	**Breakfast**	Paris Ballroom – Pre-function Area
8:30 – 9:00am	**Welcome and Introductions**	Paris Ballroom
9:00 – 10:30am	**Laying the Ground Work** A panel of diverse stakeholders who will report on federal and community efforts in addressing women, HIV and violence Frances Ashe-Goins, Office of Women's Health Gina Brown, NIH Office of AIDS Research Eddy Machtinger, University of California at San Francisco Naina Khanna, PWN-USA	Paris Ballroom

10:30 – 10:45am	**Framing Small Group Tasks**	Paris Ballroom
10:45 – 11:00am	***Break***	
11:10am – 12:00pm	**Small Group Session I** The focus will be on developing action steps for community implementation of select Interagency Working Group recommendations.	Bastille Paris Ballroom Paris Pre-Function Area
12:00 – 1:00pm	***Lunch*** ***Lunchtime presentation*** ***University of California at San Francisco and Medea Project***	Paris Ballroom
1:00 – 2:15pm	**Small Group Session II**	Bastille Paris Ballroom Paris Pre-Function Area
2:15 – 3:45pm	**Small Group Report Backs and Brief Q&A**	Paris Ballroom
3:45 – 4:00pm	***Break***	
4:00 – 4:45pm	**Large Group Discussion on Report Backs**	Paris Ballroom
4:45pm	***Close***	
5:30 – 7:30pm	***RECEPTION*** ***Speakers: Linda Scruggs & Dazon Dixon Diallo***	Paris Pre-Function Area

FRIDAY, FEBRUARY 14TH

Time	Activity	
8:00 – 8:30am	***Breakfast***	
8:30 – 9:00am	*Group Walks to Eisenhower Executive Office Building* *1650 Pennsylvania Avenue N.W.*	South Court Auditorium
9:00 – 10:45am	**Relaunch of the President's Interagency Working Group's Report** White House Panel includes Summit participants: Naina Khanna, PWN-USA (moderator)	South Court Auditorium

	Vignetta Charles, AIDS United Eddy Machtinger, UCSF	
10:45 – 11:00am	*Group Returns to Sofitel* *806 15th Street NW*	
11:00 – 11:15am	**Welcome Back and Overview of the Day**	Paris Ballroom
11:15am – 12:30pm	**Review & Discussion of Small Group Recommendations from Day 1**	Paris Ballroom
12:30 – 1:15pm	***Lunch***	Paris Ballroom
1:15 – 2:15pm	**Reactor Panel of Stakeholders** Andrew Forsyth, Office of HIV/AIDS and Infectious Disease Policy Liz Brosnan, Christie's Place **Additional panelists may be added.*	Paris Ballroom
2:15 – 3:00pm	**Next Steps**	Paris Ballroom
3:00pm	**Close**	