



The Intersection of Women, Violence, Trauma, and HIV

> OVERVIEW

More than **1 in 3** women in the United States today experience significant physical or sexual violence in their lives, most often perpetrated by current or former intimate partners.¹ Sadly, women living with HIV experience even higher rates of violence and trauma than the general female population.² The ability to effectively address the impact of violence and trauma on women living with HIV is an **essential strategy** in both improving their health and reducing new infections.

Among women living with HIV in the US:

55% experience intimate partner violence (IPV) — **2 times** the national rate.

61% have been sexually abused — **5 times** the national rate.

30% have post-traumatic stress disorder (PTSD) — **5 times** the national rate.

Source: Machtinger, et al. AIDS and Behavior. 2012;16(8):2091–2100.

injury that are associated with sex (especially forced sex) may facilitate HIV transmission.³

It may, however, come down to how a history of violence or trauma can undermine a woman's ability to protect herself and engage in self-care. For example, a woman's fear of IPV can prevent her from refusing to have sex or even asking a partner to use a condom.^{4,5}

In addition, being HIV positive is itself a risk factor for exposure to IPV because disclosure may trigger violence.³ One study showed that 45% of women living with HIV experienced physical abuse as a direct consequence of disclosing their serostatus.⁶

> IMPACT ON THE HIV CARE CONTINUUM

Research shows that trauma is strongly linked to leading causes of morbidity, mortality, and disability in the United States.⁷ This is relevant to HIV care because trauma impacts an individual's ability to advance along the HIV Care Continuum. In fact, studies indicate that women living with HIV who have experienced IPV:⁸⁻¹²

- ▶ **Take longer to be linked to care after being diagnosed.**
- ▶ **Are more likely to fall out of care.**
- ▶ **Are less likely to take antiretroviral therapy (ART).**
- ▶ **Are more likely to experience treatment failure.**

What's more, trauma and other stressful events can accelerate HIV disease progression, likely in part through compromised immune functioning.¹³

> ADDRESSING VIOLENCE AND HIV

To optimize health outcomes for women living with HIV, the impact of violence and related trauma on women's ability to access and remain in care must be recognized, and evidence-based interventions must be implemented. Ultimately, HIV and violence must be addressed together to comprehensively improve women's health.

Violence against women is shockingly widespread. In the United States, 35.6% of adult women will experience rape, physical violence, or stalking by an intimate partner in their lifetime.¹ Additionally, the majority of rapes against women (91.9%) are committed by a current or former intimate partner or an acquaintance.¹ Sexual violence committed by any perpetrator is even more prevalent:¹

- ▶ **1 in 5 women experience rape or attempted rape.**
- ▶ **1 in 6 women experience stalking.**
- ▶ **Nearly 1 in 2 women experience sexual coercion or other unwanted sexual contact.**

What's more, women living with HIV in the United States experience violence at significantly higher rates than the general population. According to one meta-analysis, 55% have experienced intimate partner violence (IPV) — more than double the national rate; 61% have been sexually abused — five times the national rate; and 30% have post-traumatic stress disorder (PTSD) — more than five times the national rate.²

> RISK FACTORS

Several studies suggest that IPV itself is a risk factor for HIV.³ This is because women who have been or are exposed to IPV are more likely to engage in behaviors that put them at risk for exposure to HIV; these behaviors can include injection drug use, lack of condom use and/or having unprotected sex, having sex with a male partner at risk for HIV, and having unprotected anal sex.³ Still another factor is the physical repercussions of sex on women's bodies, as the associated inflammation, abrasions, and

Confronting the intersection of violence and HIV among women has implications for many other populations affected by high rates of unaddressed trauma. Developing and further refining best practices will inform parallel efforts among other vulnerable populations including gay men of color and transgender women, who also experience high rates of trauma.^{14,15}

> FEDERAL GOVERNMENT RESPONSE

The necessity for a coordinated approach gained increased attention in March 2012 with the announcement of an interagency Federal Working Group on addressing the intersection of HIV/AIDS, violence against women and girls, and gender-related health disparities. The Working Group represented a tipping point in the country's awareness that unaddressed trauma fuels every aspect of the HIV epidemic among women. 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.¹⁶

> AIDS UNITED RESPONSE

In February 2014, AIDS United convened an interdisciplinary group of activists, thought leaders, academics, and federal partners to review and respond to this report. These Summit participants developed community action steps to complement many of the Working Group's recommendations, as well as to link to an advocacy agenda. The Summit recommendations include:

- ▶ **Encourage concurrent screening and testing** for both IPV and HIV by convening or expanding local or state level interagency working groups.
- ▶ **Develop training templates** to increase awareness of and screening for IPV within clinic settings; ask AIDS Education and Training Centers (AETCs) to develop and disseminate those training materials.
- ▶ **Participate in federal advocacy** across departments to integrate IPV screening into existing practices.
- ▶ **Work with the Housing Opportunities for Persons with AIDS (HOPWA) Program** to prioritize emergency and long-term housing for women living with HIV in violent situations.

DEFINITIONS ¹⁷⁻¹⁹

Intimate partner violence (IPV): Actual or threatened physical violence, actual or threatened sexual violence, stalking, or psychological aggression (including coercive tactics) by a current or former partner.

Trauma: An event, series of events, or set of circumstances experienced as physically or emotionally harmful or threatening with lasting adverse effects on functioning and well-being.

Rape: Physically forced or threatened vaginal, oral or anal penetration; includes alcohol or drug facilitated completed penetration.

Post-traumatic stress disorder (PTSD): An anxiety disorder that develops after a terrifying ordeal that involved physical harm or the threat of physical harm.

HIV Care Continuum: A model of care that refers to five stages of HIV care — diagnosis, linkage to care, retention in care, adherence to medication therapy, and viral suppression — facilitating the measurement of the proportion of individuals living with HIV who are engaged in each stage.

- ▶ **Develop best practices** from existing models and interventions for the integration of HIV and IPV linkage and bring to scale.
- ▶ **Encourage community-based collaborative interventions**, subject to rigorous evaluation, that are tied to advancing the HIV Care Continuum and patient outcomes.
- ▶ **Influence policy at the national level** by raising awareness of the intersection of women, HIV, and violence.

> WHERE DO WE GO FROM HERE?

Each day, awareness about the relationship between HIV/AIDS and violence against women grows stronger. Significant opportunities exist to improve HIV care by recognizing the impact that violence and trauma play in women's health and well-being. The challenges, of course, will occur in coordinating best practices at federal and state levels and in finding scalable responses.

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 and end the epidemic. 

¹ Centers for Disease Control and Prevention (CDC). National intimate partner and sexual violence survey. 2010. Available at: http://cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf.

² Machtiger, et al. Psychological trauma and PTSD in HIV-positive women: a meta-analysis. *AIDS and Behavior*. 2012; 16(8):2091–2100.

³ Phillips DY, Walsh B, Bullion JW, et al. The intersection of intimate partner violence and HIV in U.S. women. *JANAC*. 2014;25(15):536–549.

⁴ Silverman JG, McCauley HL, Decker MR, et al. Coercive forms of sexual risk and associated violence perpetrated by male partners of female adolescents. *Perspect Sex Reprod Health*. Mar 2011;43(1):60–65.

⁵ Wingood GM, DiClemente RJ, McCree DH, et al. Dating violence and the sexual health of black adolescent females. *Pediatrics*. May 2001;107(5):E72.

⁶ Gielen AC, McDonnell KA, Burke JG, et al. Women's lives after an HIV-positive diagnosis: disclosure and violence. *Matern Child Health J*. 2000;4(2):111–120.

⁷ Felitti VJ, Anda RF. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behavior: implications for healthcare. *The Impact of Early Life Trauma on Health and Disease*. Cambridge University Press; 2010:77–87.

⁸ Schaffer KR, Brant J, Gupta S, et al. Intimate partner violence: a predictor of worse HIV outcomes and engagement in care. *AIDS Patient Care STDS*. 2012;26(6):356–365.

⁹ Cohen MH, Cook JA, Grey D, et al. Medically eligible women who do not use HAART: the importance of abuse, drug use, and race. *Am J Public Health*. 2004;94(7):1147–1151.

¹⁰ Mugavero MJ, Raper JL, Reif S, et al. Overload: impact of incident stressful events on antiretroviral medication adherence and virologic failure in a longitudinal, multisite human immunodeficiency virus cohort study. *Psychosom Med*. 2009;71(9):920–926.

¹¹ Mugavero M, Ostermann J, Whetten K, et al. Barriers to antiretroviral adherence: the importance of depression, abuse, and other traumatic events. *AIDS Patient Care STDS*. 2006;20(6):418–428.

¹² Lichtenstein B. Domestic violence in barriers to health care for HIV-positive women. *AIDS Patient Care STDS*. 2006;20(2):122–132.

¹³ Leserman J. Role of depression, stress, and trauma in HIV disease progression. *Psychosom Med*. 2008;70(5):539–545.

¹⁴ Reif M, Huang B, Campbell J, et al. Gay identity, interpersonal references violence, and HIV risk behaviors: an empirical test of theoretical relationships among a probability-based sample of urban men who have sex with men. *JANAC*. 2004;15(2):14–26.

¹⁵ ActionAIDS, Unity. University of Pennsylvania School of Social Work. Needs assessment of transgendered people in Philadelphia for HIV/AIDS and other health and social services. 1997. Philadelphia: ActionAIDS.

¹⁶ The White House. Addressing the intersection of HIV/AIDS, violence against women and girls, and gender-related health disparities. September 2013. Available at: http://www.whitehouse.gov/sites/default/files/docs/vaw-hiv_working_group_report_final_-_9-6--2013.pdf

¹⁷ Women's Research Initiative. The intersection of violence and trauma with HIV among women issue brief. Available at: <http://www.thewellproject.org/sites/default/files/FINAL%20issue%20brief%202014.pdf>.

¹⁸ National Institute of Mental Health. What is post-traumatic stress disorder? Available at: <http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>.

¹⁹ AIDS.gov. What is the HIV care continuum? December 2013. Available at: <http://aids.gov/federal-resources/policies/care-continuum/>.