Background

FUTURES with the support of the Office of Women’s Health has been working with States to implement a brief intervention in reproductive health settings, which includes:

- Universal education on healthy relationships
- Targeted assessment for reproductive coercion
- Warm referral to domestic violence resource

Project Connect

- Provider education and evaluation of provider behavior change
- Policy and protocol change to institutionalize best practices
- Capacity building of DV programs to address health issues and provide onsite services

Implementation: Readiness

- Data-informed planning and implementation
- Shared vision and commitment
- Establish/deepen relationships
- Clear understanding of organizational structure of partners
### Implementation: Preparing the Workforce

- Staff and board training on the relationship between IPV and negative health outcomes
- Basic and advanced trauma training
- On-site, regional, statewide training
- Identify champions
- Model partnerships by co-facilitating

### Implementation: Evaluation and Dissemination

- Continuous quality improvement
- Share results both internally and externally
- Disseminate widely
- The power of stories AND numbers

### Policy: Clinic Setting Conditions

- Management buy-in
- Updating and integrating forms, procedures, EHRs, practice guidelines
- Ongoing training “built in”
- Sharing success

### Policy: Cross Pollinating Across Systems

- Interdisciplinary IPV Task Force/Workgroup
- Cross-system education and awareness building
  - Maryland: (substance use toolkit, human trafficking, home visiting),
  - Oregon: Title X Clinic Manual
- Strong clinic to domestic violence program relationships
Policy: Structuring Systems for Success

- Organizational partnerships
- New funding connections
- Legislative policy development
- Medical standards incorporate IPV assessment best practice

DV programs - Implementation

- Education sessions at shelter
- “Doctor Days” – consultations with medical residents
- Onsite gynecological exams

Implementation Considerations

- Education for staff and board members to ensure readiness
- Reproductive coercion, birth control options, emergency contraception
- How and where clinical services are provided
  - Priority appointments for shelter residents
- Modify charting system for EHR inputting
- Data Tracking

Considerations, cont’d

- Outline deliverables and expectations and establish confidentiality guidelines
- MOUs and other cooperative agreements
- Cross training
- Screening protocols at intake and discharge
Policy Changes Needed

- Address Changing Needs as They Arise
  - “Fax Back” referral
  - Bringing in support groups and hotlines
- Logistics
  - Add to liability insurance
  - Availability of Emergency Contraception
  - Transportation devices for labs, charts, and supplies
- Tracking patients, statistics and successes

Sustainability

- Capacity of DV Program to enroll clients in state medical services – so clinic can bill for services
- Project Connect has solidified the partnership with official policy changes at shelter and clinic
  - Components easily incorporated into existing services
- Longstanding and growing partnerships between and among partners increase effectiveness and engagement
- Continued education and outreach beyond original partners

Strategic Partnerships

- All agencies, departments, providers can integrate the message into their work
- Helping them see it as THEIR issue is our task
- Find the champions and help them make the connections

Gender Based Violence and HIV:
Research Update

Michele R. Decker, ScD

Associate Professor of Population, Family & Reproductive Health
Director of Women’s Health and Rights, Center for Public Health and Human Rights
Johns Hopkins Bloomberg School of Public Health
HIV among women & girls in the US

- Women and girls account for 23% of adults living with an HIV diagnosis, and 20% of new HIV infections.

- Approximately 300,000 women were living with HIV in 2013.

- Youth and young adults
  - Half of new STIs, one in four new HIV cases.

- Women and girls also risk sexually transmitted infections (STIs)
  - Chlamydia, gonorrhea, syphilis, hepatitis B, trichomoniasis, HSV 2, HPV.
  - 60 million women affected by new and existing STIs in 2013.


Racial/Ethnic Disparities in Violence

Table 4.3: Lifetime Prevalence of Rape, Physical Violence, and/or Stalking by an Intimate Partner, by Race/Ethnicity — U.S. Women, NSVS 2010

<table>
<thead>
<tr>
<th>Type of Violence</th>
<th>Non-Hispanic Black</th>
<th>Non-Hispanic White</th>
<th>Asian or Pacific Islander</th>
<th>American Indian or Alaska Native</th>
<th>Multiracial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape 1995—2002</td>
<td>5.2 1.4 1.4</td>
<td>2.4 1.0 1.0</td>
<td>3.1 1.0 0.9</td>
<td>2.1 0.7 0.6</td>
<td>2.2 0.7 0.6</td>
</tr>
<tr>
<td>Physical violence</td>
<td>7.5 1.8 1.6</td>
<td>2.8 1.0 1.0</td>
<td>2.5 0.9 0.9</td>
<td>1.5 0.5 0.5</td>
<td>2.2 0.7 0.6</td>
</tr>
<tr>
<td>Stalking</td>
<td>4.3 1.4 1.2</td>
<td>2.8 1.0 1.0</td>
<td>2.4 0.9 0.9</td>
<td>1.7 0.6 0.5</td>
<td>2.1 0.7 0.6</td>
</tr>
</tbody>
</table>

Note: Rates and estimates may not add to totals due to rounding.

Source: CDC, 2008. The American Indian or Alaska Native designation does not indicate being married or affiliated with a tribe recognized by the state. Estimates are reported as relative standard errors of 50% or less, or plus or minus 30.
HIV Care Continuum Among Women & Girls
(from CDC: https://www.cdc.gov/features/womenandhivaids/)

Dating Violence & STI/HIV: MA YRBS
(Decker et al., 2005: Pediatrics)

IPV & HIV among Indian women: DHS
(Silverman, Decker et al., 2008: JAMA)

IPV and STI/HIV

- Growing evidence links IPV with STI/HIV risk and infection (e.g., Hess et al., 2012; Maman et al, 2000; Gielen et al., 2007; Campbell et al, 2008; Wu et al, 2003; Sareen et al, 2009)

- Increasingly, prospective research links IPV with incident STI, including HIV (Weiss et al., 2008; Altworth et al., 2009; Jewkes et al., 2010; Kosyoudjian et al., 2013; O'Leary et al., 2015)

- More frequent and severe IPV among HIV positive women (Gielen et al., 2002; McDonnell et al., 2003; Wyatt et al., 2002)
### Perpetrator Condom Refusal Leading to STD

“I told him to put a condom on, he didn't. ...I went to a clinic, and they were like, "Oh, he gave you Chlamydia." [H]e said it was me messin' around with some other guy, and that's not true, 'cause I was like, "You were the only guy I was with." And he's like, "Oh, that's you, you're messin' around," he's like, "fuck you, I thought you loved me."

Miller, Silverman, Decker et al.
Qualitative interviews with adolescent perpetrators and victims of dating violence, Boston MA

### Perpetrator Condom Refusal Leading to Pregnancy and STD

“ He would never listen. ... I'm like, don't you think you should wear condoms you know I might get pregnant. And he's like, next time. I'm scared of him. I'm really scared. Like I feel like he's going to hurt me. I feel it.”

Miller, Silverman, Decker et al.
Qualitative interviews with adolescent perpetrators and victims of dating violence, Boston MA

### Recent IPV and coercive sexual risk

<table>
<thead>
<tr>
<th></th>
<th>IPV (%)</th>
<th>No IPV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom refusal</td>
<td>15.3%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Fear of asking for</td>
<td>3.3%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Mandate refusal</td>
<td>8.4%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

OR
- Condom refusal: 1.78 (1.44, 2.19)
- Fear of asking for condom: 4.37 (2.87, 6.67)
- Mandate refusal: 11.34 (7.06, 18.21)

### Anal Intercourse and HIV

- An underappreciated HIV risk factor for women & girls
- Highly efficient for HIV transmission
  - ~16 fold greater risk relative to vaginal intercourse
- IPV linked with anal intercourse, often unprotected (Silverman et al., 2011; Stockman et al., 2012; Hess et al.; Decker et al., 2013)
- Abrasions and lacerations that accompany unwanted sex may facilitate transmission

Decker, Miller, Silverman et al. 2013
Recent IPV and recent anal sex

= 3593 women ages 18-29 in family planning clinics

What about the perpetrators?

- Male IPV perpetrators engage in greater HIV risk
  - Sexual infidelity/concurrent partnerships
  - Injection drug use
  - Anal intercourse
  - Condom non-use, including coercive condom non-use

- Abuse perpetrators are more likely to be STI and HIV infected!

(Decker et al., 2009, Silverman et al., 2007; Dunale et al., 2006)

IPV Perpetration & Husband’s HIV: Husband-wife Dyads in India

Why the links? IPV and HIV

- Limited control over sex with a high risk partner
- Compromised sexual & condom negotiation
  - inability to refuse sex, or certain kinds of sex
  - lack of control over condom negotiation
  - perpetrator condom refusal and condom removal
- Coerced and forced sex
  - usually unprotected
  - may result in physical trauma and facilitate transmission
- Greater risk introduced by male violence perpetrators
  - engage in greater sexual risk behavior
  - more likely to be infected
- Diagnosis and partner notification a context for fear and abuse

Decker et al., 2009
**Violence and HIV status disclosure**

- IPV a barrier to safe, effective partner notification
- Violence can result from disclosure of HIV status
- Important for STI as well
  - Partner-expedited therapy

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**HIV status as a tool of abuse**

- Abusers can use HIV status as a tactic of abuse and coercion
  - Threats to reveal HIV status to family, friends, employer
  - Threats to use HIV status to influence parental custody decisions
  - Humiliation or degradation for being HIV positive
  - Using HIV status as an excuse for violence or abuse

---

**IPV and Fear of Partner STI Notification**

*Women ages 16-29 (n=1319) in FP clinics in Northern California;*

- Fear of Notification
- **IPV** vs. **Non-IPV**

![](chart.png)

(Decker, Miller, Silverman et al., 2011)

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**Violence and access to HIV care**

- IPV can be a barrier for HIV-positive women to access health care
- Fear of IPV as a result of disclosure can prevent women from seeking care
- Abusive partners can prevent women from accessing care
  - Threats of violence
  - Isolation
  - Stalking
**IPV and interference in medication adherence**

- HIV medication regimens can be complex and adherence is critical

- Consistent medication adherence can be a challenge in violent relationships
  - Medication interference by partners
  - Difficulty with consistently taking medication given competing priorities
  - PTSD and depression associated with low medication adherence

**Violence & HIV treatment outcomes**

- Violence and trauma constrains the success of treatment
  - Abused women less likely to use ART (Cohen et al., 2004)

- Violence and other stressful life events linked with
  - Non-adherence
  - Poor viral response (Schaffler et al., 2012; Mugavero et al, 2009; Mugavero et al., 2006; Expino 2015)

**Constellations of Risk**

- Sex trade
- Mental Health
- Substance use
- IPV

**Sex trade**

- Historically, public health focus on female sex workers (FSWs) from infectious disease standpoint
  - FSWs suffer disproportionate HIV burden
  - ~11 times that of women of reproductive age (Baral et al., 2012)

- Growing recognition of GBV against women in sex work, often with significant STI/HIV implications
  - Trafficking or exploitation
  - Forced/coerced sex, and condom-related coercion once involved

- WHO convened first meeting on best practices in responding to GBV (2013)
IPV and sex work, sexual exploitation and economically motivated sex

- IPV and violence from other perpetrators are common among women involved in sex work/sex trade, including sexual exploitation, and economically motivated sex
  - Abusive partners can pressure women into sex trade as a means of control or obtaining scarce resources
  - Sex trade as a means of escaping abusive relationships
  - Women who trade sex experience abuse from clients, police and pimps

Violence & STI/HIV among FSWs

- Client Violence: 37% OR_adj=3.44 (1.09, 8.99)
- 15%

HIV epidemic impact of reducing violence against FSWs?

- Epidemiological modeling in two settings
  - Ukraine (concentrated epidemic) and Kenya (generalized epidemic)
  - ~25% reduction in new infections for FSWs; even assuming ART scale-up
  - Infections averted among FSWs over five years: ~4500 in Ukraine; ~18,000 in Kenya

Moving Forward!

- Integrated HIV and IPV prevention interventions show promise!
  - SHARE (Rakai Uganda; Wagman et al., Saturday 11:25am)
  - Stepping Stones (South Africa; Jewkes et al)
Key Messages

- Gender-based violence undermines successful HIV prevention and treatment
  - In the general population
  - Among women who trade sex
- Trauma-informed informed care should acknowledge risks beyond patient's control

- Critical to address the intersections of GBV and HIV
- HIV Risk
  - Anal intercourse
  - Context of sex work or trade
- Access to care and successful treatment once infected

Thank you!

- Need a reference? Check out our factsheet at Futures
- Questions?
- mdecker@jhu.edu

A conceptual model showing intersections of gender-based violence and gender inequity for women.

Jewkes, 2010, Science
HIV/IPV CONNECTIONS - ETIOLOGY
(MAMAN ET. AL. '99 & SINCE)

- Impossible to negotiate safe sex if IPV - well substantiated - multiple studies
- Women accused of infidelity if ask for safe sex
- Males with other partners unknown to women (WHO’04)
- Fear of being beaten for being tested; notifying partner of positive status; delay in treatment
- Substance abuse (increased substance abuse w/ IPV)
- Immune system depression with stress
  - 2010 - immune system alteration with stress of IPV, PTSD
- Genital trauma - increased transmission; anal sex
  - More severe forced sex, multiple forced sex
- Increased STD’s & untreated STD’s - increased transmission through vaginal wall - activated immune system

MULTIPLE US SAMPLES

- 35-45% of physically abused women also physically forced into sex
- If asked, majority say multiple - many times
- If asked, a substantial proportion (up to ½) of forced sex was anal sex

FORCED FIRST SEX/SEXUAL INITIATION

- Forced first sex (sexual initiation) as a result of IPV (“dating violence”) (Stockman et al, 2012)
- Forced first sex 21% of sexual initiation for girls in the US whose sexual debut < 14 yo (Stockman et al ‘09)
- First sexual violence in an ongoing violent relationship?
- In US - anal sex not considered “sexual intercourse” (or “real sex”) by many adolescents therefore “safe sex” practices not necessary & can remain “abstinent” even if anal sex
  - Abusive young men exploit these myths
  - “He’ll either hit me or quit me” (Sweet-Jemmott ‘05)
FINDINGS

- In Baltimore - Recent IPV significantly associated with inconsistent condom use
  - (AOR = .24 (0.080.72))
  - Forced sex associated w/inconsistent condom use - Anal Sex
- Less than half women, abused or not, engage in risky sex behaviors - less than 25% USVI women - significantly less likely than women in Baltimore
- Most of increased risk related to STI’s and partner having other partners
- Few demographics independently related to exchange sex or other woman's risk behaviors -
- Recent IPV & past year drug use both independently associated with exchange sex

PHYSIOLOGICAL EFFECTS OF IPV ON IMMUNE SYSTEM NOT TOTALY CLEAR

- PTSD & co-morbidity differential effects (Woods ‘04)?
- Immune system dysfunction is both suppression AND activation
- Inflammation markers C-reactive protein (CRP) and interleukin-6 (IL-6) increase w/IPV - Newton ‘11; Granger, S. Woods - ‘11
- Multiple physical injuries - e.g. strangulation, TBI, also leads to immune system effects
- Immune system activation leads to decreased vaginal wall barrier to HIV virus - immune system activated with STI’s also - IPV associated with increased STI’s

IMMUNE SYSTEM EFFECTS

- HPA axis - hypothalmic - pituitary - adrenal gland interactions
- Stress of abuse, multiplied by poverty, racism for women of color, other stressors - but even separate from other stressors -activates HPA & produces corticosteroids & catecholamines
- Suppresses Th1 cell cytokine (fights bacteria & viruses) production
- Depression has same effects on immune system
- May result in lowered immunity to HIV - Immune system dysfunction also includes activation
- May contribute to faster decrease in CD4 count, more development of complications of AIDS, more death
  - Stress/PTSD/depression leads to decreased CD4 counts in HIV+ women - Ickovics, '01; Leserman ‘03, ’08

• Of 422 African American and African Caribbean women who experienced physical abuse:
  - 157 (37%) reported an experience of forced sex - by partner - majority said forced sex repeated (many times)
  - 31 of 123 (23%) of those experiencing forced sex (who responded to question) reported forced anal sex -

- Study - "CROSS-CUT" Women Experiencing Partner Abuse Compared to Those Never Abused In Baltimore & USVI (Funding by CERC - Caribbean Exploratory Research Center #P20MD002286 NIH/NIMHD G. Callwood, PI.)