The Facts on Violence Against Women and HIV/AIDS

VIOLENCE AGAINST WOMEN IS WIDESPREAD AND PERVASIVE

- More than 1 in 3 women (35.6%) in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.[1]
- Among victims of intimate partner violence, more than 1 in 3 women experienced multiple forms of rape, stalking, or physical violence.[1]
- Between 20% and 50% of women indicate that their first sexual experience was forced.[2]
- An estimated 13% of women have experienced sexual coercion in their lifetime (i.e., unwanted sexual penetration after being pressured in a nonphysical way); and 27% of women have experienced unwanted sexual contact.[1]
- Nearly 1 in 5 women (18.3%) have been raped in their lifetime, including completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration.[1]
- Approximately 80% of female victims experienced their first rape before the age of 25 and almost half experienced rape before age 18 (30% between 11-17 years old and 12% at or before the age of 10).[1]
- About 35% of women who were raped as minors were also raped as adults compared to 14% of women without an early rape history.[1]
- More than half (51.1%) of female victims of rape reported being raped by an intimate partner and 40.8% by an acquaintance.[1]

VIOLENCE UNDERMINES SUCCESSFUL STI/HIV RISK REDUCTION

- Unprotected sex has been found more common among women and girls who have experienced abuse.[3-5]
- Coercive condom dynamics and fear of negotiation are common for those in abusive relationships. Girls who experienced dating violence were 2.9 times more likely to fear the perceived consequences of negotiating condom use than non-abused girls, and over 5 times as likely to report experiencing negative consequences of condom requests.[6, 7]

- In relationships where abuse and power imbalances are present, women lack control over sexual and condom negotiation. Some cannot safely say "no" to having sex or doing other things their partner wants them to do. This limits their ability to reduce their own risk for HIV.[8-10]

- It is important to consider sexual coercion, including coerced sexual initiation, in addition to forced sex; sexual coercion is associated with greater sexual risk and substance use.[11]

- Women also describe anal intercourse as stemming from violence and power imbalances;[9, 10] given the HIV transmission efficiency of unprotected anal sex,[12] recognizing the role of violence and coercion in anal intercourse is particularly important.

- Under high levels of fear for abuse, women with high STI knowledge were more likely to use condoms inconsistently than nonfearful women with low STI knowledge.[13]

VIOLENCE PUTS WOMEN AT RISK OF HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS

- More than one-third (38.8%) of adolescent girls tested for STI/HIV have experienced dating violence.[14]

- Adolescent and adult women with a history of abuse are more likely to experience a STI, including HIV;[3, 14-16] adult women exposed to both physical and sexual partner violence are over three times more likely to be infected,[15] and women who experienced intimate partner violence were over 3 times more likely to have a diagnosis of HIV/AIDS.[16]

- Prospective studies confirm that partner violence is a risk factor for sexually transmitted infection including HIV.[17-19]

- Abrasions and injury can result from violent sexual assault,[20] resultant trauma may facilitate HIV transmission.

- In a sample of predominantly African American women, those with symptoms of depression and a history of IPV were 19 times more likely to have been treated for a STI in the past year.[21]

VIOLENCE COMPROMISES SUCCESSFUL PARTNER NOTIFICATION AND TREATMENT

- Abused women are more likely to fear partner notification following STI/HIV diagnosis.[22]

- In a study with 310 HIV-positive women, 45% experienced physical abuse as a direct consequence of disclosing their HIV status.[23]

- Violence,[24, 25] and more broadly constructed stressful life events[26, 27] can compromise ART uptake and adherence, and are linked with poor treatment response.

- IPV is a considered an under-recognized barrier to women's ability to obtain regular medical care for HIV/AIDS; partners can undermine medication adherence and medical appointments.[28]

- Trauma and other stressful events can accelerate HIV disease progression, likely in part through compromised immune functioning.[29]

- HIV-positive men and women who experience IPV are more likely to engage in unprotected sex.[30]

- HIV-positive women experienced more lifetime abuse, more frequent abuse and a higher severity of abuse.[31, 32]

- HIV-positive women who experienced recent IPV were more likely to report inconsistent condom use, pregnancy, and abuse stemming from requests for condom use.[33]

- HIV-positive women who have experienced IPV in the last year reported the lowest health-related quality of life in all four areas of functioning (cognitive, physical, role, social) and three areas of well-being (mental health, energy/fatigue, and quality of life).[34]

VIOLENCE PERPETRATORS EXHIBIT GREATER STI/HIV RISK BEHAVIOR AND INFECTION

- Men who rape or are physically violent with partners have been found:
  - to have more sexual partners, including partners outside the relationship[35-38]
  - to have greater engagement in unprotected sex, including coerced unprotected sex[38-40]
  - to have greater engagement in harmful substance use[35, 36]
  - more likely to be STI/HIV infected[39, 41, 42]

WOMEN and MEN IN CORE HIV RISK GROUPS SUFFER HIGH LEVELS OF ABUSE

- Drug-involved women suffer higher levels of abuse, and more severe abuse; substance use and violence is considered bidirectional[43, 44]

- Women involved in the sex industry,[45] including those trafficked for sexual exploitation,[46] suffer a high burden of HIV; violence from clients, pimps, and police is common and significantly associated with STI/HIV risk behavior and infection.[42, 47, 48]

INTERVENTION MAKES A DIFFERENCE

Risk reduction is possible with survivors of abuse:

- In a 2003 study, abused women who received 8-session intervention were 3.6 times more likely to decrease unprotected sex occasions or maintain consistent safer sex and more than 5 times more likely to have a safe sex conversation with their main partner.[49]

- In a 2006 study with female adolescents who had a history of gender-based violence, an HIV intervention led to a substantial reduction in HIV-associated sexual behaviors and reductions in frequencies of sexually transmitted infections.[50]

Violence prevention is possible in the context of HIV prevention

- In South Africa, the IMAGES intervention – a blend of microfinance with gender equity and HIV education - was found to reduce women's experiences of controlling behavior from an

intimate partner; the intervention decreased physical and sexual violence victimization by more than 50%.[51]

- In South Africa, the Stepping Stones intervention was found to reduce men's sexual risk behavior and perpetration of intimate partner violence.[52]

IMPLICATIONS FOR STI/HIV PROGRAMS

- Clients may not be able to negotiate safe sex, including condom use, and engagement in anal intercourse with abusive partners.

- IPV may be a more immediate threat to a client than a sexually transmitted infection or HIV status, prompting those in abusive relationships to prioritize their immediate safety over sexual risk reduction.

- Partner STI/HIV notification may be dangerous for clients experiencing abuse.

- Notifying the abusive partner of a client with a sexually transmitted infection or HIV may lead to an escalation of violence and/or threats against the client. When working with clients who disclose abuse or are at high risk of experiencing abuse, assess the level of danger with the client and identify the safest way to proceed.

RECOMMENDATIONS

- Integrate violence and IPV screening within routine STI/HIV prevention and treatment services.

- Ensure that staff is trained to address violence, and refer patients to support services.

- Provide cross-training between STD/HIV programs and violence support services.

- Connect clients with local domestic violence/sexual assault resources and services.

- Educate clients about how violence can influence risk behaviors. Client education can help IPV victims who are diagnosed with a sexually transmitted infection and/or HIV to understand the connection between victimization and their sexual health. For example, informing a client about the risk of Chlamydia is also an opportunity to explain to clients that women in abusive relationships are at increased risk for Chlamydia.

- Prescribing a medication that can be taken at one time versus a prescription that the client would need to take home and take over a period of time may be a safer, more effective treatment option for a client who is experiencing abuse and is fearful of their partner finding out.

- Teach safety planning skills.

- Develop a policy on partner notification for clients disclosing abuse.

- Design program evaluation to include sexual risk reduction and safety from violence.

- Create a safer environment for screening, intervention, and education about IPV. These strategies include:

- Displaying posters, pamphlets, and information on services for victims and perpetrators
- Having information on IPV in waiting rooms, other public areas, and in private areas including exam rooms and bathrooms
- Having a private, sound-proof area where your conversation with your client can not be overheard or creating as much distance as possible when screening a client who is accompanied by a partner or other person

- Ensure that responding to IPV is system-wide, sustainable, monitored, and not dependent on one individual who is championing the cause.

This fact sheet was updated September, 2013 by Futures Without Violence in collaboration with Michele R. Decker, ScD MPH, Johns Hopkins Bloomberg School of Public Health and Elizabeth Miller, MD, PhD, University of Pittsburgh School of Medicine.

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