



POSITIVE WOMEN'S NETWORK
USA

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National Day of Action to End Violence Against Women Living with HIV *Breaking our Chains – Ending the Culture of Violence*

In the United States, women living with HIV (WLHIV) are more likely to die from violence, trauma, and the effects of lifetime abuse, than HIV-related causes. Violence and trauma are particularly devastating for women of color, young women, low-income women, and transgender women.

Over the three decades of the epidemic, the proportion of deaths among WLHIV attributable to HIV-related causes have declined, from 85% in 1996 to 65% in 1998, to 40% in 2004ⁱ, and to approximately 25% in 2014ⁱⁱ. Today, many deaths of WLHIV are due to overdose, violence, liver disease and heart disease, all conditions known to be related to unaddressed childhood and adult trauma and to coping mechanisms related to complex post-traumatic stress disorder (PTSD). Abuse history, ongoing violence, and traumatic experiences may also negatively impact ability to engage in healthcare and to maintain adherence to lifesaving medications for women with HIV.

Violence and Abuse:

- 61.1% of US WLHIV have experienced lifetime sexual assault – five times the rate among the general population.
- 55.3% of WLHIV have experienced intimate partner violence (IPV), almost twice the rate reported in a national sample of women.
- 39.3% of WLHIV have experienced childhood sexual abuse (CSA), more than twice the rate in the general population.
- The estimated rate of lifetime abuse (type unspecified) among WLHIV is 71.6%, compared to 39% in a national sample.ⁱⁱⁱ
- Lifetime effects of trauma: Women living with HIV are **five times more likely** to have Post-Traumatic Stress Disorder (PTSD) as the general population of women.ⁱⁱⁱ

Engagement in Medical Care and Adherence to Treatment:

Women with HIV who experienced recent abuse or the threat of abuse are:

- Three times more likely not to be linked to care within 90 days^{iv}
- Twice as likely to be lost to follow-up^v
- Half as likely to be on anti-retroviral therapy^{vi}
- 2-3 times more likely to experience non-adherence to anti-retroviral therapy^{vii,viii}
- 2-4 times more likely to experience inability to achieve viral suppression when prescribed anti-retroviral therapy^{6,ix}

Death: In one longitudinal cohort study, the Women's Interagency HIV Study (WIHS), WLHIV who reported abuse within the preceding 30 days were 42% more likely to die than women who did not report abuse within the past 30 days.

Women living with HIV experience violence at the individual, community and institutional level.

- **Individual Violence:** Women living with HIV may face violence in their own homes and in personal relationships with acquaintances and intimate partners. In some instances, disclosure of HIV status may lead to violence.
- **Community Violence:** Women living with HIV face violence at the community level as transphobia, HIV-related discrimination, and cultural scripts about gender norms promote sexual harassment, denial of medical care or other necessary services, and misogyny.
- **Institutional Violence:** Women living with HIV face violence at the institutional level where practices and policies steeped in stigma and discrimination exist at all levels of public institutions, including the legal system and law enforcement. Such policies and practices are oppressive, as in the case of HIV-specific criminalization laws, policies that force people with HIV to keep their incomes below certain levels in order to access lifesaving services, and laws that control and police women's bodies, including women's rights to control their own sexuality and reproduction.

PWN-USA Recommends

We demand bold leadership to address violence against women living with HIV and its traumatic effects from the federal, state and local governments, clinics, and community-based organizations.

What the Federal Government can do:

- The Office of National AIDS Policy (ONAP) should reinstate the Federal Interagency Working Group on Violence Against Women, HIV/AIDS, and Gender-related Health Disparities.
- ONAP should designate a senior-level position in its office to lead on HIV care and prevention issues for women.
- ONAP should develop and implement a mechanism to meaningfully involve civil society in assessment and implementation of the National HIV/AIDS Strategy, with a focus on involving networks of people living with HIV.
- National HIV/AIDS Strategy implementation should include objectives that prioritize implementation of trauma-informed care and comprehensive sexual and reproductive health services for women living with HIV.
- The Department of Health and Human Services (DHHS) National HIV/AIDS Strategy 2020 Implementation Plan should include specific plans to:
 - Measure and improve screening rates for current abuse and coercion for women living with HIV receiving medical care over the next five years
 - Increase capacity to provide intervention and referrals for domestic violence for women living with HIV
 - Measure and improve screening rates for lifetime trauma and abuse for women living with HIV in care over the next five years
 - Increase capacity to provide services that help WLHIV in medical care and receiving services heal from lifetime trauma and abuse and which reduce symptoms of post-traumatic stress disorder and complex post-traumatic stress disorder

- Create and implement a standard for non-stigmatizing and culturally relevant sexual and reproductive healthcare services which uphold the full range of sexual and reproductive rights for people living with HIV.

What states can do:

- Repeal all laws that criminalize HIV exposure and nondisclosure
- Eliminate “condoms as evidence” laws and other laws criminalizing sex workers and those targeted as sex workers.
- Develop state HIV/AIDS strategies that commit to:
 - Increase screening and response for intimate partner violence in HIV care and service delivery settings
 - Increase screening for and response to lifetime trauma in HIV care and service delivery settings
 - Increase HIV testing, referrals and linkage to care for women accessing domestic violence services

What counties and cities can do:

- Mandate HIV sensitivity and anti-stigma trainings for law enforcement officials, health department workers, violence specialists, and child protection services.
- Increase collaborations between HIV and domestic violence providers.

What clinics can do:

- Implement trauma-informed primary care as described by the University of California San Francisco Women’s HIV Program and Positive Women’s Network USA (see resource list below)
- Develop mechanisms for clients to meaningfully evaluate and inform service delivery.
- Hire staff, including management, who reflect the constituency served.
- Integrate mental health services and social support services on-site
- Partner with community-based organizations led by women living with HIV
- Fund, support, and promote homegrown interventions that address violence and trauma.

What community-based organizations and other providers can do:

- Integrate and standardize routine intimate partner violence screening and counseling in all health and wellness settings, as per the Institute of Medicine’s recommendations and Affordable Care Act’s subsequent adoption of women’s preventative services^x.
- Train and build the capacity of providers, health care worker staff, and peers in intimate partner violence shelters, HIV care clinics, health care networks, and local and state health departments to have the knowledge and skills to address signs of violence and trauma, including screening and counseling to ensure women living with HIV feel safe and that their status is confidential.

Additional Resources:

From Treatment to Healing: The Promise of Trauma-Informed Primary Care, Women’s Health Issues Journal

[http://www.whijournal.com/article/S1049-3867\(15\)00033-X/fulltext](http://www.whijournal.com/article/S1049-3867(15)00033-X/fulltext)

Journal Article by Edward L. Machtinger, MD & Naina Khanna, et al.

A review of evidence linking trauma to health, providing practical guidance to clinicians, researchers, and policymakers for effective responses to trauma in primary care settings.

***Trauma and HIV: A Call for Intersectional Approaches*, The Huffington Post**

Blog by Charles Stephens & Naina Khanna

http://www.huffingtonpost.com/charles-stephens/trauma-and-hiv-a-call-for_b_7849250.html

Discussing how trauma for PLHIV is differentially experienced across race, gender identity, class, sexual identity, and socioeconomic status.

***Untangling the Intersection of HIV & Trauma: Why It Matters and What We Can Do*, GMHC Treatment Issues**

Blog by Suraj Madoori & Naina Khanna

http://www.poz.com/pdfs/gmhc_treatmentissues_2013_9.pdf

Discussing the ways unaddressed trauma in the lives of PLHIV negatively impacts access to and engagement in care.

SAMHSA's Concept of Trauma and Guidance for a Trauma Informed Approach

<http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884>

Offers a framework for how an organization, system, service sector can become trauma-informed.

ⁱ French, A.L., et al., *Trends in mortality and causes of death among women with HIV in the US: A ten-year study*. Journal of acquired

ⁱⁱ Weber, Kathleen; MD Personal Communication to E. Machtinger. *Women's Interagency HIV Study*. 2014

ⁱⁱⁱ Machtinger, E. L., Wilson, T. C., Haberer, J. E., & Weiss, D. S. (2012). Psychological trauma and PTSD in HIV-positive women: a meta-analysis. *AIDS and Behavior*, 16(8), 2091-2100.

^{iv} Siemieniuk, R.A., et al., *Domestic violence screening: Prevalence and outcomes in a Canadian HIV population*. AIDS Patient Care STDs, 2010. 24(12): p. 763-70.

^v Siemieniuk, R.A., et al., *The clinical implications of high rates of intimate partner violence against HIV-positive women*. J Acquir Immune Defic Syndr, 2013. 64(1): p. 32-8.

^{vi} Kalokhe, A.S., et al., *Intimate partner violence among HIV-infected crack cocaine users*. AIDS patient care and STDs, 2012. 26(4): p. 234-240.

^{vii} Leserman, J., et al., *Stressful life events and adherence in HIV*. AIDS patient care and STDs, 2008. 22(5): p. 403-411.

^{viii} Mugavero, M.J., et al., *Overload: impact of incident stressful events on antiretroviral medication adherence and virologic failure in a longitudinal, multisite human immunodeficiency virus cohort study*. Psychosomatic medicine, 2009. 71(9): p. 920-926.

^{ix} Machtinger, E.L., et al., *Recent trauma is associated with antiretroviral failure and HIV transmission risk behavior among HIV-positive women and female-identified transgenders*. AIDS and Behavior, 2012. 16(8): p. 2160-70.

^x Institute of Medicine. (2011). Clinical Preventive Services for Women: Closing the Gaps. Washington, D.C.: Committee on Preventive Services for Women and Board of Population Health and Public Health Practice; Health Resources and Services Administration (HRSA). (2011). Women's Preventive Services: Required Health Plan Coverage Guidelines. Retrieved from <http://www.hrsa.gov/womensguidelines/>