Intimate Partner Violence and HIV

Dr Rageshri Dhairyawan

Consultant Physician in Sexual Health and HIV Medicine

Barts Health NHS Trust, London, UK

Rageshri.dhairyawan@bartshealth.nhs.uk

@crageshri

Before we start…

Sensitivity warning

This talk will be focusing on women, but men and transgender people also experience IPV. There are limited data on these populations.

Case 1: ‘Fatou’

- 19 year old woman from Senegal.
- In UK for 1 year on a visitor visa
  - Living with husband of 1 year
  - No other family or friends in UK
  - Unemployed
  - Speaks French with little English
- Diagnosed with HIV on routine booking bloods in the antenatal clinic at 12 weeks pregnancy.
- Never tested for HIV before.

Fictitious case. Case studies are representative only

‘Fatou’ - 2nd trimester

- Started on ART
- Regular review by multidisciplinary team
  - HIV Dr/nurse
  - Health advisor
  - Specialist midwife
  - Obstetrician
  - Peer support worker

Fictitious case. Case studies are representative only

‘Fatou’ - 2nd trimester

- Discussion about sharing HIV status with her husband
  - Patient keen but worried about his reaction
  - Strategies discussed
- Patient brings husband into clinic, and with support from the Health Advisor, tells him her status
  - He appears supportive
  - Tests negative on rapid HIV test

Fictitious case. Case studies are representative only

At 22 weeks of pregnancy

- ‘Fatou’ found on street at 2am
  - Facial injuries
  - Torn clothing
- Alleged physical assault by husban
- Police involved – restraining order
- Patient referred to a VAW service
- Moves out of area
- Referred to another hospital for ongoing HIV and antenatal care

Fictitious case. Case studies are representative only

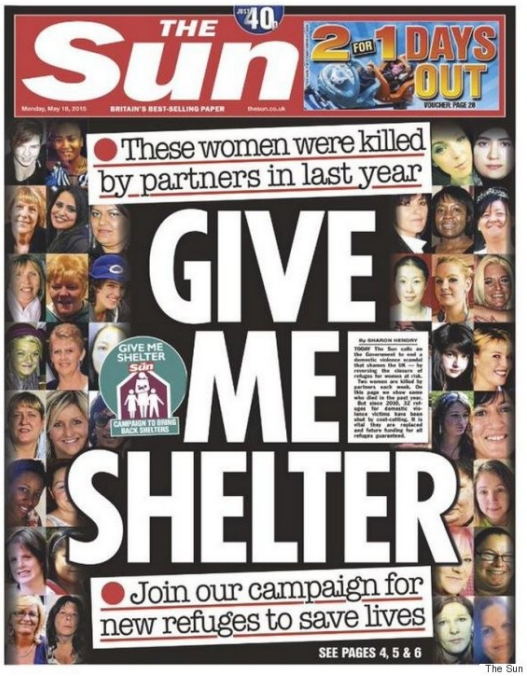
Intimate Partner Violence- definition

"… any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours."

Examples:

Physical	Slapping, kicking, burning, strangulation etc.
Sexual	Coerced sex through force, threats, intimidation, manipulation etc.
Psychological	Isolation, verbal aggression, humiliation, stalking, withholding funds, controlling victim's access to healthcare or employment etc.

The headlines



The Sun

- In the UK
  - 2 women per week killed by a partner or ex-partner (DOH 2005)
  - Leading cause of morbidity in 19-44 yr old women (Home Office, 2005)

But, it is a silent epidemic

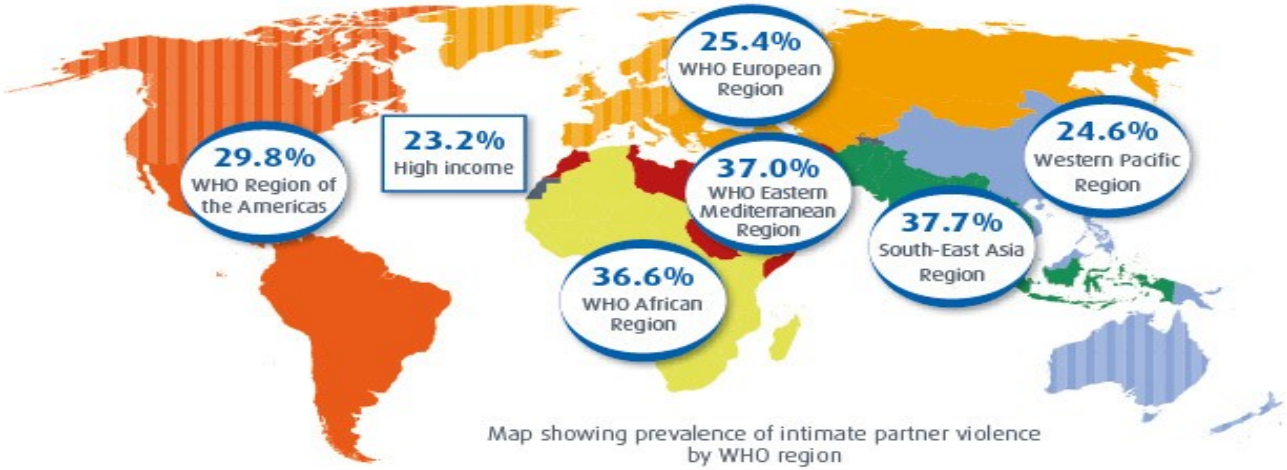
- WHO multi-country study on domestic violence and women's health
- One fifth to two thirds of women had never told anyone about their partner's violence before.

Garcia Moreno, C et al. 2006. Prevalence of IPV: findings from a WHO multicountry study on women's health and domestic violence. The Lancet, 368 (9543) pp1260-1269

World Health Organization

VIOLENCE AGAINST WOMEN: PREVALENCE

1 in 3 women throughout the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner



Map showing prevalence of intimate partner violence by WHO region

All statistics can be found in the report entitled Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, by the World Health Organization, the London School of Hygiene & Tropical Medicine, and the South African Medical Research Council, found here:

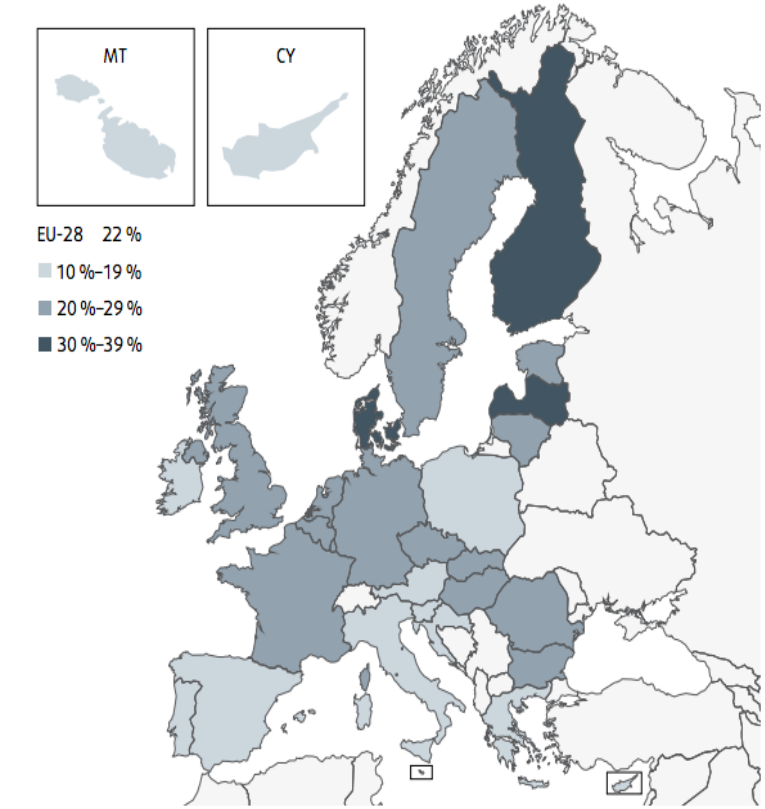
http://www.who.int/reproductivehealth/publications/violence/en/index.html

EU survey (2014): IPV experienced by women

Physical/sexual violence – 22%

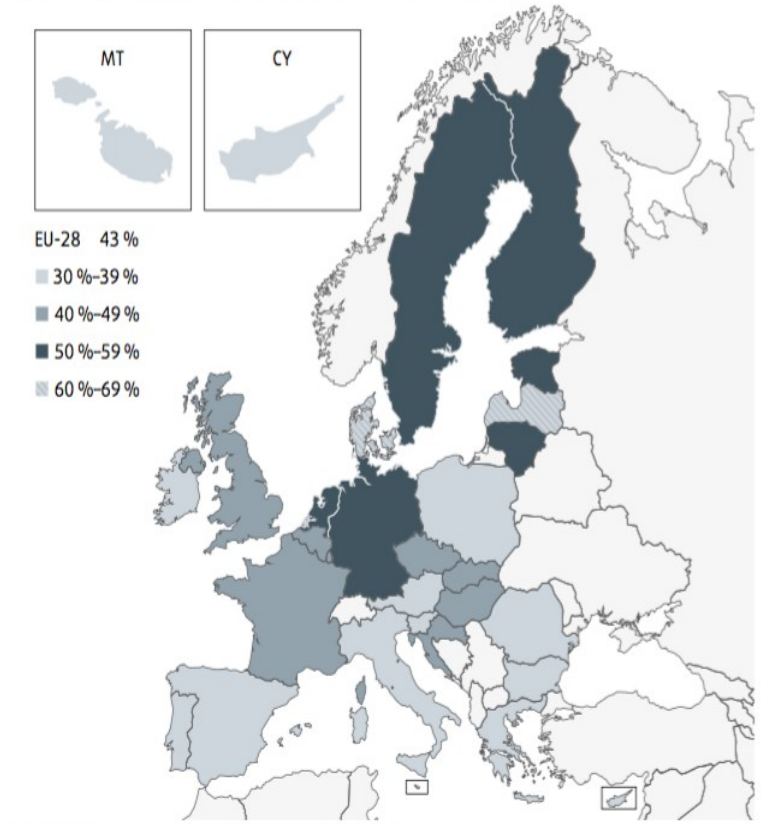
Psychological violence – 43%

Figure 1 b: Physical and/or sexual partner violence since the age of 15, EU-28 (%)



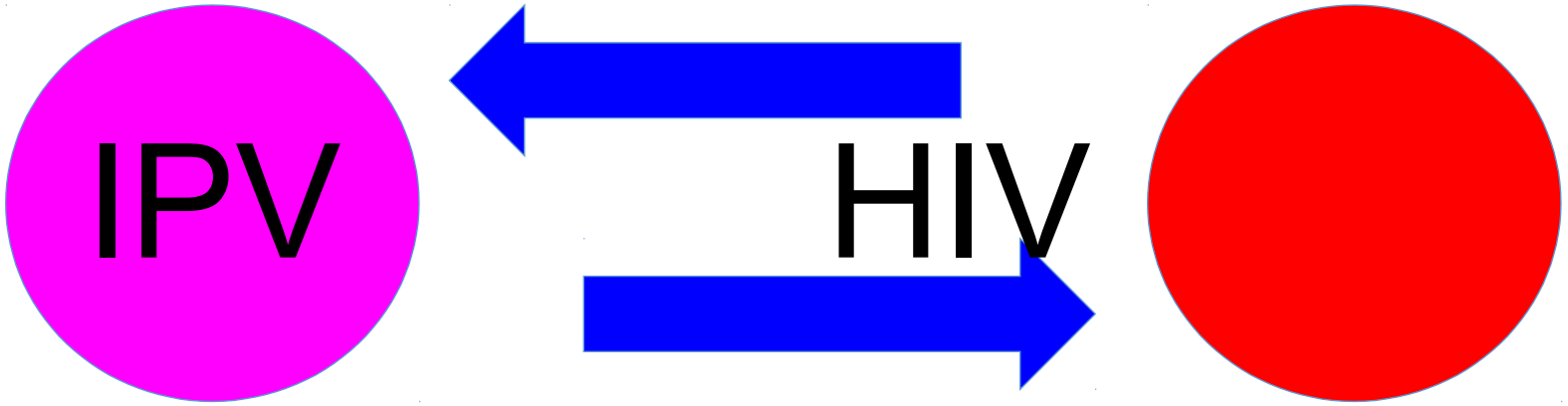
Source: FRA gender-based violence against women survey data set, 2012

Figure 2 a: Psychological violence by a partner since the age of 15, EU-28 (%)

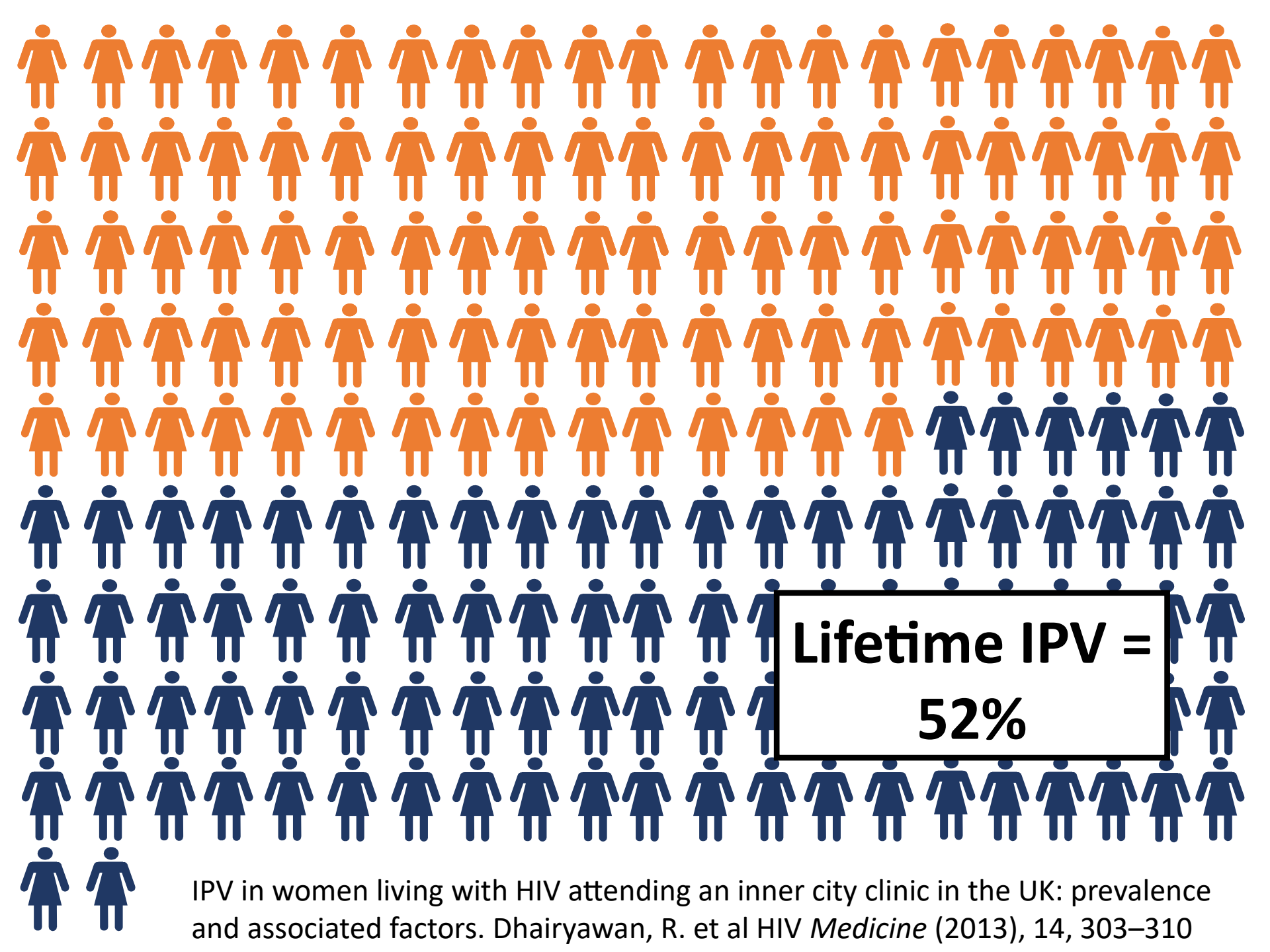


Source: FRA gender-based violence against women survey data set, 2012

http://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report


IPV
HIV


October 23: Day of Action to #EndVAWHIV
#SaveWomensLives #pwnspeaks
Break the culture of violence
against women with HIV and all women!
imgflip.com

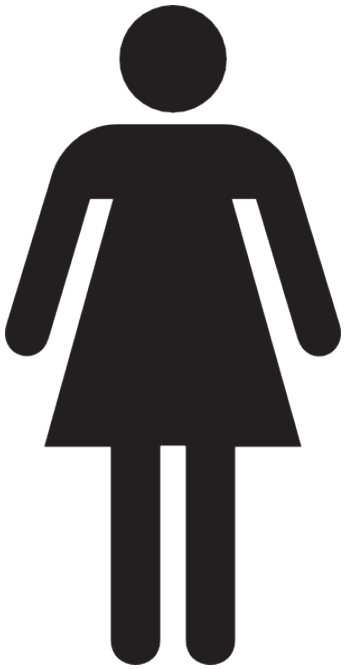


IPV in women living with HIV attending an inner city clinic in the UK: prevalence and associated factors. Dhairyawan, R. et al HIV *Medicine* (2013), 14, 303–310

IPV increases vulnerability to HIV

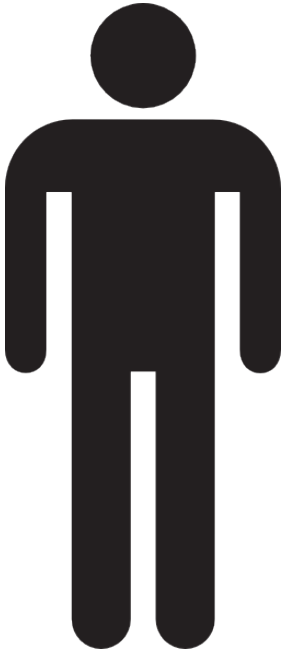
Women who have experienced IPV are 1.5 x more likely to acquire HIV (likely higher in marginalised groups)

Coerced and forced sex



Long term psychological effects, poor mental health, low self esteem, substance abuse

Inability to negotiate condoms and safer sex



Perpetrator more likely to carry HIV

More partners

More unprotected sex

More sexually transmitted infections

- GBV and HIV: reviewing the evidence for links and causal pathways in the general population and high risk groups. Dunkle KL, Decker MR. Am J Reprod Immunol 2013; 69 (Suppl 1):20-26
- IPV and HIV infection amongst women: a systemic review and meta-analysis. Li Y et al. J Int AIDS Soc 2014; 17:18845

HIV increases vulnerability to IPV

- When sharing status (disclosure).
  - Can cause an already violent relationship to escalate
  - May cause violence
  - *Health professionals advocate disclosure of HIV status to partners, but this may not be possible if there is IPV or fear of IPV*
- Women may be blamed for bringing HIV into the family as often test first eg. in pregnancy.
- Women may be unable to leave an abusive relationship due to dependence on the perpetrator legally and financially.

Factors affecting disclosure in South African HIV positive pregnant women. Makin JD et al. AIDS Patient Care STDS 2008;22:907-916

Ways in which Abusers Use Their Own or Victims' HIV Status as a Weapon of Coercion

- Threats to reveal HIV status to children, family, friends, employer.
- Reinforcing a victim's guilt about the HIV status of children.
- Sexually humiliating or degrading the victim for having HIV. Telling the victim she is "dirty" or undesirable.
- Threatening or refusing to assist the victim when she is sick.
- Abusers may use the victim's HIV status as an excuse for their violence.
- Abusers who are living with HIV may fake illness in order to convince victims not to leave, or to manipulate them into providing care.

The Interface between IPV and HIV/AIDS in S Africa. H Morrison, accessed 2015

Impact of IPV on HIV care

- IPV after disclosure of HIV test results amongst pregnant women in Harare, Zimbabwe. Shamu S et al. PLoS One 2014; 9:e109447
- Domestic violence in barriers to healthcare for HIV-positive women. Lichenstein B. AIDS Patient Care STDS 2006;20:122-132
- IPV and engagement in HIV care and treatment among women: a systematic review and meta-analysis. Hatcher AM et al. AIDS 2015, 29:2183-2194.

Violence leaves scars

- Double stigma of HIV & IPV means that women rarely talk about their experiences of violence and do not access support

- The experience of violence may deter women from entering new relationships or disclosing for fear of rejection or abuse >> isolation & loneliness

Case 2: ‘Angela’

- 35 year old White British woman
- First pregnancy aged 16 (no contact after birth from father)
- Married aged 18. Husband 20 years older.
- IPV started in 2nd pregnancy
  - Controlling behaviour & physical violence
- Diagnosed with HIV 2008 when unwell
- Started on HIV medications
- Husband told her he tested negative

Fictitious case. Case studies are representative only

‘Angela’

- Violence escalated
  - Used HIV status to control her more (opens post, threatens to tell people)
  - Shouted in public that she has “AIDS” and will “die soon”. Children overheard.
  - He told her he has a baby with someone else, but she should stay with him as no one else would want her
  - Police/social services involved

Fictitious case. Case studies are representative only

‘Angela’ - 2015

- Intermittent engagement with HIV services
  - Taking meds intermittently
  - Forgetful
- Insomnia
- Low mood
- Weight gain
- Husband no longer in contact
- Lives with 2 children, unemployed

Fictitious case. Case studies are representative only

‘Angela’ - review at home

- House in state of disrepair
- Angela living in her bedroom
  - Does not go out unless necessary
  - Sends children out to buy food and walk dog
  - Sleeps with light and TV on
  - Shares bed with 15 year old daughter
  - No shared “family space” as living room reminds her of when she used it as a refuge from her husband in the bedroom

Fictitious case. Case studies are representative only

‘Angela’- Management plan

- GP prescribed antidepressants
- Talking therapy from psychologist
- Advice on sleep hygiene
- Charity helped her buy some household essentials
- Encouraged to leave house more often eg. To walk dog
- Taken of HIV meds for several months whilst her mental health improved

Fictitious case. Case studies are representative only

VAW living with HIV

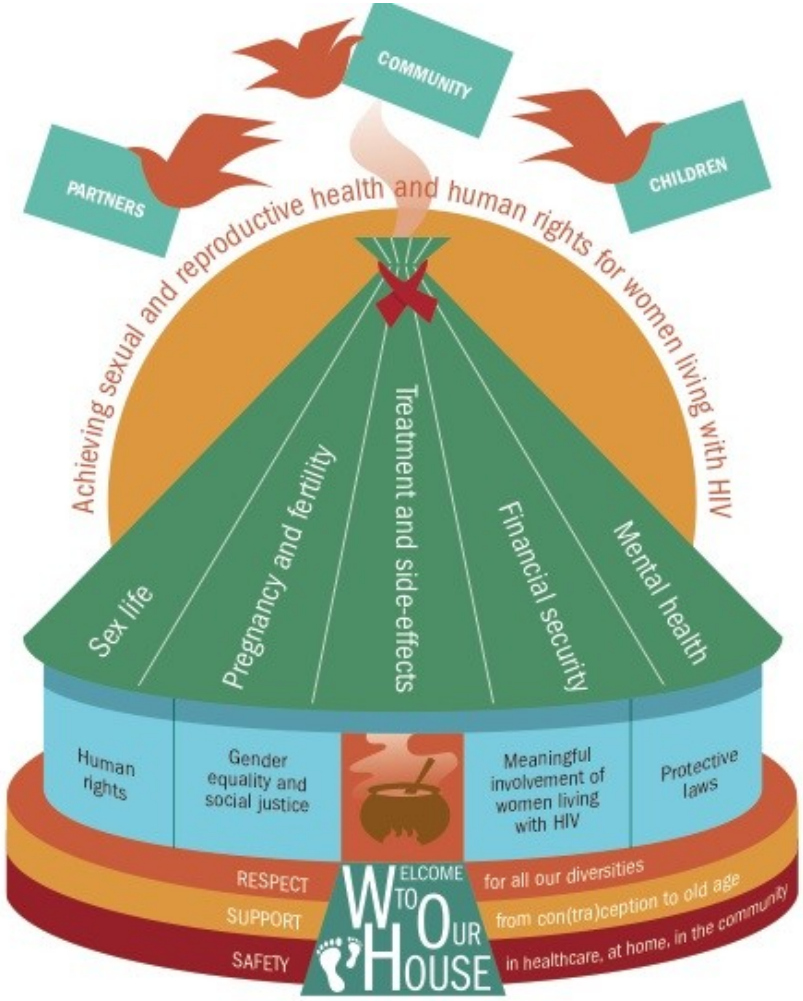
"Violence against positive women is any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV"

Hale and Vazquez (2011)

VAW with HIV is fuelled by structural and personal gender power imbalance, discrimination and stigma.

Violence against women living with HIV/AIDS: a background paper. Hale, F and Vazquez M. 2011. http://genderandaids.unwomen.org/pt/resources/2011/06/violence-against-women-living-with-hivaids-a-background-paper

"Violence. Enough already": Findings from a global participatory survey among women living with HIV (2015)



- 945 women living with HIV from 94 countries
- 89% of 480 respondents to an optional section on VAW reported having experienced or feared violence, either before, since and/or because of their HIV diagnosis.

Orza, L et al. Journal of the International AIDS Society 2015, 18(Suppl 5):20285

Types of VAW living with HIV

Continuum throughout life span.

- IPV – HIV acquisition, after diagnosis.
- Self-inflicted violence – blame, deliberate self harm, substance abuse.
- Violence within the family and community – rejection, having to move away.
- Violence in health services – forced disclosure, confidentiality breach, discrimination, forced abortion/sterilisation, negligence
- Corporate/business practices – restrictions to employment, HIV testing without consent, forced resignation, sacking

What can we do?

BHIVA/BASHH/FSRH guidelines for the sexual & reproductive health of people living with HIV

Laura Waters[1], Emily Lord[2], Nicola Mackie[3], Louise Melvin[4], Jane Ashby[1], Chitra Babu[5], Benjamin Black[6], Deborah Boyle[7], Rageshri Dhairyawan[8], Yvonne Gilleece[9], Sarah Hardman[10,11], Sharon Jay[12], Vinod Kumar[13], Chris O'Connor[14], Keith Radcliffe[15], Alison Wright[16], Shema Tariq[1,17], Shaun Watson[18], Katherine White[1]

BHIVA
British HIV Association

FSRH The Faculty of Sexual & Reproductive Healthcare

BASHH
British Association for Sexual Health and HIV

Recommendations

- We recommend routine enquiry about domestic abuse, including intimate partner violence, in sexual health & HIV clinics in accordance with NICE guidelines.

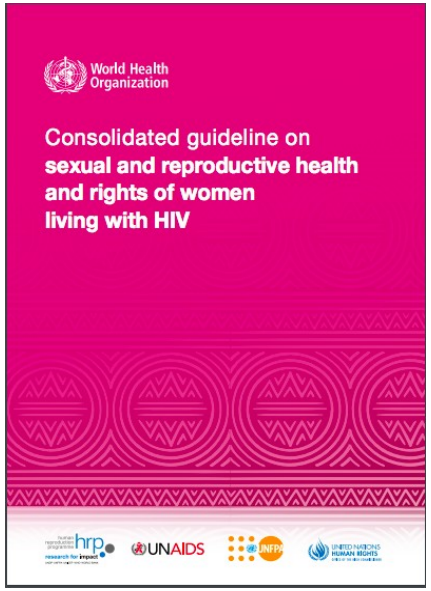
- We recommend services develop local guidelines & pathways based on BASHH guidance prior to the introduction of routine questioning (Responding to domestic abuse in sexual health settings. BASHH 2016).

Responding to Domestic Abuse in Sexual Health Settings

BASHH Sexual Violence Group
February 2016

Authors: Rachel Sacks, Rageshri Dhairyawan, Daniella Brawley, Michelle Carroll, Rachel Caswell, Charlotte Cohen, Katherine Coyne, Christine Donohue, Praveen Jayadeva, Emma McCarty, Alison Mears, Rimi Shah, Kate Shardlow, Deborah Wardle

WHO SRHR guideline (2017)



Violence against women services

REC B.4 (NEW): WHO recommends that policy-makers and service providers who support women living with HIV who are considering voluntary HIV disclosure should recognize that many fear, or are experiencing, or are at risk of intimate partner violence.	Strong recommendation, low-quality evidence
REC B.5 (NEW): WHO recommends that interventions and services supporting women living with HIV who are considering voluntary HIV disclosure should include discussions about the challenges of their current situation, the potential associated risk of violence, and actions to disclose more safely, and facilitate links to available violence prevention and care services.	Strong recommendation, low-quality evidence

Protection from violence and creating safety

GPS A.6: Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.[27]

GPS A.7: Health and other support services should be provided to all persons from key populations who experience violence. In particular, persons experiencing sexual violence should have timely access to comprehensive post-rape care in accordance with WHO guidelines.

GPS A.8: Law enforcement officials and health- and social-care providers need to be trained to recognize and uphold the human rights of key populations and to be held accountable if they violate these rights, including perpetration of violence.

Conclusion

- IPV and other forms of VAW are experienced commonly by women living with HIV and have multiple impacts on health, safety and wellbeing.
- The response must include multiple sectors including health and social care, VAW sector, the law and policy makers.
- Human rights approach addressing,
  - women's safety, confidentiality and healthcare.
  - societal and cultural norms.
  - structural issues such as laws and policies that may unfairly discriminate against women living with HIV.
  - **Training and empowering women living with HIV and ensuring they are involved in planning efforts to address this issue.**
- More research needed into IPV and violence against men and transgender people living with HIV.

Any Questions?

rageshri.dhairyawan@bartshealth.nhs.uk

@cr shri