

Intersection of Intimate Partner Violence and HIV in Women

What We Know about IPV and HIV in Women

- Intimate partner violence (IPV) includes physical violence, sexual violence, threats of physical or sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner.¹
- Findings from the 2010 National Intimate Partner and Sexual Violence Survey (NISVS) indicate that 35.6% of women in the United States have experienced rape, physical violence, or stalking by an intimate partner in their lifetime, and 5.9% or 6.9 million women experienced these forms of violence in the year prior to the survey.²
- In addition, 1 in 5 women have experienced an attempted, completed, or alcohol-drug facilitated rape (defined as a physically forced or threatened vaginal, oral, and/or anal penetration) in their lifetime, mostly by a current or former partner.
- Approximately 80% of female victims of rape experienced their first rape before the age of 25.²
- Nearly 1 in 2 women have experienced other forms of sexual violence in their lifetime (e.g., sexual coercion, unwanted sexual contact).²

Mechanisms

Exposure to IPV can increase women's risk for human immunodeficiency virus (HIV) infection through

- forced sex with an infected partner
- limited or compromised negotiation of safer sex practices
- increased sexual risk-taking behaviors

Source: Maman, S. et al. 2000. The intersections of HIV and violence: Directions for future research and interventions. *Social Science & Medicine* 50(4):459-478.



- Over 1.1 million people in the United States are estimated to be living with HIV and nearly 1 in 5 is unaware of their infection.^{3,4}
- Approximately 50,000 Americans become infected with HIV each year.³
- Women and adolescent girls accounted for 20% of new HIV infections in the United States in 2010³ and represented approximately 21% of HIV diagnoses among adults and adolescents in 2011.⁴
- African Americans bear the greatest burden of HIV among women; Hispanic women are disproportionately affected. Of new infections in 2010, 64% occurred in blacks, 18% were in whites, and 15% were in Hispanics/Latinas.³ The rate of new infections among black women was 20 times that of white women, and over 4 times the rate among Hispanic/Latina women.³
- The most common methods of HIV transmission among women are high-risk heterosexual contact (87% for black women, 86% for Hispanic women) and injection drug use.^{3,4}



Centers for Disease Control and Prevention



Links between IPV and HIV

The association between violence against women and risk for HIV infection has been the focus of a growing number of studies. Findings from these studies indicate:

- Women and men who report a history of IPV victimization are more likely than those who do not to report behaviors known to increase the risk for HIV, including injection drug use, treatment for a sexually transmitted infection (STI), giving or receiving money or drugs for sex, and anal sex without a condom in the past year. This is true even when other factors such as demographic characteristics, other unhealthy behaviors (smoking, heavy drinking, high body mass index) and negative health conditions (e.g., stroke, disability, and asthma) are similar.⁵
- HIV-positive women in the United States experience IPV at rates that are higher than for the general population.⁶ Across a number of studies, the rate of IPV among HIV-positive women (55%) was double the national rate, and the rates of childhood sexual abuse (39%) and childhood physical abuse (42%) were more than double the national rate.⁷
- Rates of violence victimization among HIV-positive women are comparable to those for HIV-negative women drawn from similar populations and with similar levels of HIV risk behaviors.⁸⁻¹² However, HIV-positive women may experience abuse that is more frequent and more severe.^{6,8}
- Women in relationships with violence have four times the risk for contracting STIs, including HIV, than women in relationships without violence.^{6,13-15}
- Fear of violence can influence whether some women get tested for HIV. However, in one US study, fear of partner notification and partner violence were not statistically associated with women's decisions to get or not get an HIV test.¹⁶
- Sexual abuse in childhood and forced sexual initiation in adolescence are associated with increased HIV risk-taking behaviors, including sex with multiple partners, sex with unfamiliar partners, sex with older partners, alcohol-related risky sex, anal sex, and low rates of condom use¹⁷⁻²⁰ as well as HIV infection,²¹ in adult women.

Studies of HIV-Positive Women

Several studies have examined the relationship between violence and the timing of becoming infected with HIV or disclosing HIV status. These studies suggest that IPV can be both a risk factor for HIV, and a consequence of HIV.

- A history of victimization is a significant risk factor for unprotected sex for both HIV-positive women and men.²² HIV-positive women and gay/bisexual men reporting a history of violence perpetration are also more likely to report engaging

in unprotected sex, particularly when drugs were used in conjunction with sex.²²

- HIV serostatus disclosure may be an initiating or contributing factor for partner violence.^{23,24} In US samples, 0.5-4% of HIV-positive women report experiencing violence following HIV serostatus disclosure.²⁵ Violence perceived to be triggered by HIV disclosure was as high in years following diagnosis as in the initial year of diagnosis.²⁴
- Relationship violence and trauma history can compromise the health and prevention practices of women living with HIV. Recently abused women have more than 4 times the rate of antiretroviral therapy failure, and of not practicing safe sex, as women who have not experienced abuse recently.²⁶

Studies of Women with a History of Abuse

- Forced sex occurs in approximately 40 to 45 percent of physically violent intimate relationships and increases a woman's risk for STIs by 2 to 10 times that of physical abuse alone.^{13,14}
- Women who had ever experienced forced sex were more likely to report HIV risk behaviors but less likely to have been tested for HIV despite greater perceived likelihood of having HIV than non-abused women.²⁷
- Women who had been physically abused as adults were only one-fifth as likely to report consistent condom use after two safer sex counseling sessions as women who had not been abused.²⁸
- Women who had experienced both physical and sexual violence, compared to women who reported physical violence alone, were more likely to have had a recent STI (14% vs. 4%), to have had an STI during the relationship (43% vs. 20%), to use alcohol as a coping behavior (72% vs. 47%), and to have been threatened when negotiating condom use (35% vs. 10%).¹⁵
- Women who experience IPV or sexual violence are at greater risk for a range of adverse health consequences, including increased prevalence of stress, depression, and chronic anxiety than their non-abused counterparts.²⁹⁻³¹ A recent national study found that women who experienced rape or stalking by any perpetrator or physical violence by an intimate partner in their lifetime were more likely than women who did not experience these forms of violence to report having asthma, diabetes, and irritable bowel syndrome, and both women and men who experienced these forms of violence were more likely to report frequent headaches, chronic pain, difficulty sleeping, activity limitations, poor physical health, and poor mental health than women and men who did not experience these forms of violence.²
- Significant associations have also been found between IPV and altered red blood cell and decreased T-cell function^{32,33} and relationships between stress, depression,

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CDC focuses on preventing intimate partner violence before it happens and preventing new HIV infections.



and other psychosocial factors with disease progression have been found in HIV-infected persons.³⁴⁻³⁶

- Women with HIV have nearly six times the national rate of post-traumatic stress disorder.⁷ Chronic depression has been associated with greater decline in CD4 cell count in women living with HIV, and HIV-positive women with chronic depression are more than twice as likely to die than HIV-positive women with limited or no depression, even when other health and social factors are similar.

What is CDC doing to address these problems?

CDC focuses on preventing intimate partner violence before it happens and preventing new HIV infections. CDC's work focuses on three areas: 1) understanding these problems, 2) identifying effective interventions, and 3) ensuring that states and communities have the capacity and resources to implement prevention approaches based on the best available evidence. Some examples of CDC's work are provided below.

Understand the problem

- Gathering information about the problems through the National Intimate Partner and Sexual Violence Survey, the National HIV Surveillance System and other CDC surveillance data.
- Examining the developmental pathways of violence perpetration, including those for IPV perpetration, among young women and men who have grown up in severely distressed neighborhoods in cities or areas where risk for HIV is also high.
- Studying ways that women might negotiate condom use with partners while avoiding violent reactions. For example, condom requests that describe HIV as a common problem affecting everyone are more effective than requests citing partner behavior or characteristics.³⁸

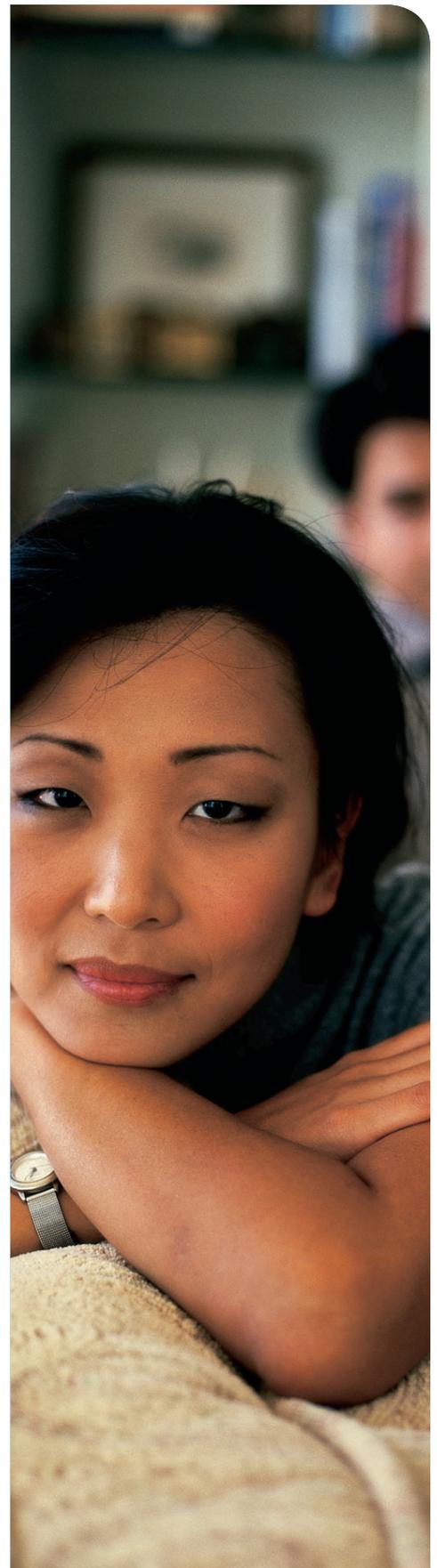
Develop, evaluate and identify effective interventions

- Funding rigorous evaluations of strategies such as Green Dot and Second Step: Student Success through Prevention to identify effective approaches aimed at preventing sexual violence before it occurs.
- Funding rigorous evaluations of other bystander (persons who observe intimate partner violence) approaches aimed at changing gender norms, attitudes and behaviors with campus and other populations.

- Examining an enhanced home visitation program to prevent intimate partner violence through a randomized trial that builds on the Nurse Family Partnership program.
- Developing and evaluating a comprehensive teen dating violence prevention initiative, *Dating Matters™*, based on the current evidence about what works in teen dating violence and sexual violence prevention.
- Rigorously testing the impact of family-based and dyad (couple)-based primary prevention strategies on the outcome of physical IPV perpetration and identified mediators with populations at risk for IPV.
- Supporting the development and evaluation of an economic development intervention – a strategy that has been shown to reduce both IPV and HIV.
- Developing and testing HIV prevention strategies in communities where HIV is most heavily concentrated and expanding targeted efforts using a combination of evidence-based approaches.
- Researching microbicides—creams or gels that can be applied vaginally or anally before sexual contact to prevent HIV transmission.
- Supporting clinical trials of pre-exposure prophylaxis (PrEP), including a CDC trial in Botswana which found that PrEP reduced the risk of heterosexual transmission of HIV by roughly 63% in the study group overall.

Implement and disseminate effective strategies

- Strengthening sexual violence prevention efforts through the Rape Prevention and Education Program by supporting strategies to prevent first-time victimization and perpetration; implementing primary prevention strategies such as engaging bystanders, educating youth about healthy relationships, and changing social norms; operating statewide and community hotlines; and building state and local capacity for program planning, implementation, and evaluation. All 50 states have convened diverse sexual assault prevention planning committees and developed state sexual assault prevention plans to guide this work forward.
- Supporting the DELTA FOCUS Program to promote primary prevention strategies that address intimate partner violence through funding, training, and technical assistance. As part of the DELTA FOCUS program, CDC's Violence Prevention Program funds 10 state domestic violence coalitions to implement and evaluate strategies aimed at addressing community and societal factors associated with IPV.
- Working to further reduce mother-to-child HIV transmission in the US by supporting perinatal HIV prevention campaigns, enhanced surveillance for HIV-



infected mothers and babies, education programs, and capacity building among health care providers and public health practitioners.

- Developing and disseminating *Take Charge. Take the Test.*[™], a social marketing campaign designed to encourage HIV testing among African American women, and the *Let's Stop HIV Together* campaign to raise awareness and fight HIV stigma.
- Supported the identification, packaging and national dissemination of effective HIV behavioral interventions, including those that address violence in the context of HIV prevention for women, such as *WILLOW*, for adult women living with HIV infection, *Sister to Sister* for HIV-negative women, and *Connect* for serodiscordant couples.
- Through the *Act Against AIDS Leadership Initiative (AAALI)*, partnering with leading national organizations serving populations hardest hit by HIV to intensify HIV prevention efforts. Through AAALI, CDC partners with national organizations serving African American women such as the Black Women's Health Imperative, the Congressional Black Caucus Foundation, the National Council of Negro Women, and Sigma Gamma Rho Sorority, Inc.

CDC also collaborates with other parts of the federal government that provide leadership and resources for service provision. More could be done to integrate violence prevention and HIV programming and response into health services, including family planning, reproductive health, maternal and child health, and infectious disease policies and programs which provide important entry points for identifying and responding to adolescents and women who experience violence or are at risk for HIV.



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For more information about HIV and VAW, visit www.cdc.gov/hiv and www.cdc.gov/violenceprevention.

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