FUTURES WITHOUT VIOLENCE™

Formerly Family Violence Prevention Fund

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.[2]

- Between 20% and 50% of women indicate that their first sexual experience was forced.[3]

- 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.[4]

- 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.[5]

- 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).[6]

- About 35% of women who were raped as minors were also raped as adults compared to 14% of women without an early rape history.[7]

- More than half (51.1%) of female victims of rape reported being raped by an intimate partner and 40.8% by an acquaintance.[8]

VIOLENCE AND SEXUALLY TRANSMITTED INFECTIONS

- According to a 2003 study, compared to women who reported never experiencing IPV, women who reported experiencing current or past IPV were:
    - 2.9 times as likely to have multiple sexual partners in the past year
    - 2.5 times more likely to report having a past or current STI
    - 2.1 times more likely to never use condoms
    - 3.6 times more likely to use condoms less than half of the instances of sex with their primary partners versus using condoms 100% of the time
    - 3.0 times more likely to report having a partner with a known HIV risk factor.[9]

- 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.[10]

- A 2000 study found that women disclosing physical abuse were 3 times more likely to experience a STI, and women disclosing psychological abuse were 2 times more likely to experience a STI. [11]

- More than one-third (38.8%) of adolescent girls tested for STI/HIV have experienced dating violence.[12]

- Girls who experienced physical dating violence were 2.8 times more likely to fear the perceived consequences of negotiating condom use than non-abused girls.[13]

- In a sample of predominantly African American women, researchers found that women 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.[14]

VIOLENCE PUTS WOMEN AT RISK OF HIV

- Women who experienced intimate partner violence were over 3 times more likely to have a diagnosis of HIV/AIDS. [15]

- HIV-positive women experienced more frequent abuse and a higher severity of abuse.[16]

- HIV/AIDS infection might be elevated due to compromised immune systems due to cumulative stress, depression, trauma, PTSD. [17]

- Violent sexual assault can cause trauma to the vaginal wall that allows easier access to HIV.[18]

- 12% of HIV/AIDS infections among women in romantic relationships are due to intimate partner violence. [19]

- Based on a study of 310 HIV-positive women:
    - 68% experienced physical abuse as adults
    - 32% experienced sexual abuse as adults
    - 45% experienced physical abuse as a direct consequence of disclosing their HIV status.[20]

- Women who reported engaging in sex with an HIV-infected partner or an injecting drug user were
    - three times more likely to have experienced any form of physical/injurious IPV
    - four times more likely to have experienced severe physical/injurious IPV
    - 3.6 times more likely to have experienced any form of sexual IPV in the past six months compared to women who did not have sex with such partners.[21]

- Women who reported injecting drugs in the past six months were significantly more likely to have experienced physical and/or sexual IPV in the past six months.[22]

- A 2005 study found that HIV-positive men and women who experience IPV were more likely to engage in unprotected sex. [23]

- Men who rape or are physically violent with partners are shown to have more sexual partners and more frequent intercourse (therefore are more at-risk of HIV/AIDS exposure).[24]

- Safer sex practices are usually controlled by the batterer (negotiation is risky*).*[25]

- HIV-positive women who experienced recent IPV were more likely to report inconsistent condom use, pregnancy, abuse stemming from requests for condom use.[26]

- Many women say they cannot choose whether condoms or other protection will be used during sex. Some cannot safely say "no" to having sex or doing other things their partner wants them to do. This increases the risk for HIV/AIDS.*[27]*

- IPV is an under-recognized barrier to women's ability to obtain regular medical care for HIV/AIDS.[28]

- 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).[29]

INTERVENTION MAKES A DIFFERENCE

- 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.[30]

- In a 2006 HIV prevention study involving female adolescents who had a history of gender-based violence, the HIV intervention led to a substantial reduction in HIV-associated sexual behaviors and reductions in frequencies of sexually transmitted infections.
    - In the same study, the HIV prevention intervention did not increase the incidence of subsequent abuse during the 12-month follow-up period. Thus, the intervention reduced the young women's risk of HIV without placing them at harm for further victimization.[31]

- A 2007 study of women in South Africa found that those who received intervention reported less controlling behavior from an intimate partner and more than 50% decrease in IPV.[32]

IMPLICATIONS FOR STI/HIV PROGRAMS

- Clients may not be able to negotiate safe sex with an abusive partner.

- IPV may be a more immediate threat to a client than a sexually transmitted infection or HIV status.

- Partner 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 the safest way to proceed.

RECOMMENDATIONS

- Integrate violence and IPV screening.
- Ensure that staff is trained to address violence/IPV.
- Provides cross-training between STD/HIV programs and domestic violence programs.
- 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 impact of Chlamydia on fertility 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.
- Developed 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.

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