WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Intersection of Intimate Partner Violence and HIV

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh and I'd like to welcome to the Intersection of Intimate Partner Violence and HIV webinar. This webinar as brought you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center or HIV TAC The Partnerships for care project is a three year, multi agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act. The goals of the project are to one, expand prevention of HIV testing prevention, care, and treatment in health centers serving communities highly impacted by HIV. 2, to build sustainable partnerships between health centers and their state health department. And 3, improve health outcomes among people living with HIV, especially among racial and ethnic minorities.

The project is supported by the HIV Training, Technical Assistance, and Collaboration Center, HIV TAC. Our speakers today are Surrabhi Kukke and Kate Vander Tuig. Ms. Kukee has a Master's degree in Public Health from Harvard University and serves as a health project manager at Futures Without Violence. She focuses on capacity building and resource development for health care workers, on assessment and response to IPV, and the intersections between IPV and HIV. Prior to her state and national work in the US, she in the international development sector, providing operational and evaluation support to community based HIV/AIDS and reproductive health programs in Africa and South Asia. She has also provided technical and research support to international agencies, including the United Nations Development Program, UNIFEM, and Action AID.

Our first speaker today will be Kate Vander Tuig. Ms. Vander Tuig holds a Bachelor's of Arts degree from the University of Michigan, with a concentration in community based change. She has worked as a community educator and advocate to survivors of sexual and domestic violence in Washington, DC and San Francisco, California, and currently works as a program specialist on the health team at Future Without Violence. In her role at Futures, she supports the National Health Resource Center on Domestic Violence, through material development, technical assistance, and provider education. Her areas of interest include primary prevention, community informed policies and programs that support survivors, and the connection of health to healthy relationships throughout the lifespan. She believes that strong connected communities, not one organization or system, will end gender-based violence. Please join me in welcoming Ms. Vander Tuig.

KATE VANDER TUIG: Thanks so much, Steve, and thank you to HRSA and P4C folks for having us speaking on this webinar. So CMEs, x continuing medical education are available for doctors and DOs, if you fill out the evaluation that's linked at the end of this webinar. And neither Surrabhi and I have any conflicts of interest for providing this information today. So

before we get started, we wanted to find out from you all, the folks who are viewing this webinar, what are your roles in the P4C program, just so we can make sure we're tailoring our discussion to your role?

So it looks like the pole has come up there. And go ahead everyone, and just fill out what your role is, and I think then we'll broadcast the results just to be able to see who folks are and where folks are coming from. Excellent. So it looks like mostly on the call today are folks coming from health centers who are direct service providers at those health centers, some health center leadership, and then also some federal folks as well. Great. So glad you could all join us today. Thanks for the polling.

All right, so today, we're really going to get into explaining the intersection of gender-based violence or intimate partner violence incidents and HIV risk, particularly for marginalized communities. We're going to be able to utilize interventions for clients who are at risk for HIV and IPV, and then hopefully improve outcomes for women living with HIV in HIV care by addressing that violence and trauma. So in order to be able to address the violence and trauma, we really need to be able to kind of make the connection and understand the intersection between HIV and violence.

To do that we have to have understanding of what gender-based violence is. It's really a general term that's used to capture what violence that occurs as a result of normative gender roles and unequal power dynamics within society And it includes domestic violence, sexual harassment, rape, sexual violence, sexual violence during conflict, trafficking, forced prostitution, and other violations of human rights that are particularly gendered. And this gender-based violence is so often a source of trauma in the lives of women, queer, and trans people, and particularly in the lives of women, queer, and trans people living with HIV and that's what we're going to be talking about today.

And then one of the particular forms of gender-based violence that we are going to be zeroing in on particularly in the data that we're providing and also the intervention that we are providing for you all to utilize is abusive relationships. And that's when one person in a relationship is using a pattern of harmful methods and tactics to gain and maintain power and control over the other person. You'll often hear this referred to as intimate partner violence, domestic violence, domestic abuse, things like that, dating violence as well.

And I highlight that as a pattern, because it's not a one time thing. It's a cycle that include many different tactics and methods that are all kind of listed in that little hand graphic that are utilized. And then I also highlight that it comes back to power and control. It really comes back to someone wanting to gain power and control over the other person that's targeted that one person. It isn't an anger management issue, for example. And there are many reasons that survivors are staying in abusive relationships. And if you want more information on the dynamics of domestic violence, please visit us online at futuresaboutviolence.org where you can find more information about the dynamics of abusive relationships.

So some of you may be familiar with many of these statistics, but I just want to underscore that gender-based violence, particularly intimate partner violence, is so widespread and so very

pervasive. So more than one in four women and one to 10 men are going to be experiencing intimate partner violence in their lifetime. These rates are actually a little bit higher for marginalized communities, like queer and trans folks, particularly bisexual people who are experiencing quite a bit higher rates of intimate partner violence in their lifetime, and trans folks who are experiencing quite a bit higher rate of sexual violence throughout their lifetime. So just wanted to highlight how pervasive this issue is. So if it's one in four women, and you see 20 women a day in your health center, that's a quarter of those women, five of those women are going to have experienced intimate partner violence. So just wanted to underscore that.

So associated with intimate partner violence and gender-based violence are so very many poor health outcomes. People who are experiencing IPV, sexual assault, and stalking are going to a much more likely report frequent headaches, chronic pain, and by chronic pain that includes chest pain, back pain, abdominal pain, GI problems, and this has been shown again and again in several different studies particularly the studies predominantly from the CDC. And it just really underscores that this is a health issue. This isn't just something that we want to address because we want to make our patients' lives better, but is really an underlying cause of so many health issues, that if you're not addressing the violence that's occurring, it's so difficult to actually address the health problems.

And folks, feel welcome to type into the chat pod any of these health consequences that you think are either particularly surprising, that you didn't know were associated with gender-based violence or that you think that your colleagues, your coworkers, would be particularly surprised about. One that we always hear folks are surprised about is that asthma is very commonly associated with the experiences of violence. So what we're really trying to get at is that gender-based violence both increases HIV infections and poor health outcomes, but is also a significant consequence of HIV infection.

And this is a cycle that we really have to be aware of and need to be addressing as providers. So in terms of understanding the problem, gender-based violence increases the chances of becoming HIV infected. And women are two to five times more likely than men to contract HIV from heterosexual intercourse. Can anyone tell me why they think that might be? And you can go ahead and type your chats into the chat box. Why might that be?

STEVE: I'm not seeing anything being entered right now.

KATE VANDER TUIG: OK. Thanks so much, Steve. So we're going to get into why that might be. Women and girls are victims of gender-based violence, who are victims of gender-based violence are four more times more likely to become infected with STIs, including HIV. And women who were beaten or dominated by their partners were 48% more likely to become infected with HIV than women in nonviolent relationships. And these stats and the stats and I'm going to go into after this are really just setting the context to understand how interconnected and prevalent and co-occurring these two epidemics really are.

Women disclosing abuse, physical abuse, were three times more likely to be experiencing an STI, and women who were discussing a psychological abuse where two times more likely to be experiencing an STI. And so this really highlights that it's a spectrum of control, getting back to

that pattern, that cycle of control. And it's not just sexual violence but putting folks at risk for contracting HIV. And I just want to highlight that a lot of our status today are specific to women who've experienced violence. And that's just because most of the statistics out there about the intersection of violence and HIV are about women just because those are the predominately folks who are experiencing it the most. That's not to say that other folks aren't also experiencing intimate partner violence and getting HIV.

In a sample of men, men who have sex with men are also at a higher risk for experiencing both HIV and intimate partner violence. And among men who had experienced IPV, there were higher rates of depression. 24% of female patients have experienced physical abuse after disclosing their HIV status and 45% had feared such a reaction. So this is really that, not only is gender-based violence increasing the risk of getting HIV, but HIV is really a driver of violence as well. So many folks who were disclosing their HIV status, either feared a very violent reaction or did actually experience one.

Over half of women living with HIV have experienced gender-based violence. And that's considerably higher than the national prevalence among women as we had outlined. And in one study of one HIV clinic, 67% to 83% of the women there were in currently or had been in abusive relationships. Among women who were experiencing GBV, those women who are HIV positive also experienced more violent and more frequent abuse compared to those women who were not HIV positive. So just to say that of everyone, all the women who are experiencing abuse, those women who are HIV positive, it's much more violent and frequent episodes of intimate partner violence. And the stats are similar with men, of a sample of HIV positive men, 39% reported physical intimate partner violence by a primary sexual partner and 17% reported physical intimate partner violence by a casual sexual partner.

So why are we talking about co-occurrence of HIV and gender-based violence. And what it really comes down to is that HIV is a social disease with clinical implications, meaning that the infection moves through social and sexual networks, and that it's no coincidence that communities that are most marginalized by stigma and discrimination are also the ones who are most vulnerable to HIV. And then lastly clinical outcomes are really reflecting the prevailing inequities and health disparities. So that people who are living with HIV are not just the dying because they have HIV. They are largely not dying because they have HIV, in fact, and it's really that the underlying trauma, substance abuse, domestic violence, homicide and other societal factors that are making folks who are living with HIV have shorter lives.

So this kind of underscores that we as providers, we're not just treating a virus. It's not just about viral load and lessening the viral load. It's really about treating the whole person, which includes addressing experiences of trauma and kind of meeting them where they're at. And to just kind of wrap up with all those statistics, I know that was a lot of statistics, but I just want to kind of set the context. In addition to gender-based and physical violence, trauma and PTSD more generally impact HIV positive women at disproportionate rates when compared to the general population. So some of these rates, they're really alarming even though, you know, I'm familiar with these statistics, they still blow me away. Lifetime trauma rate for women living with HIV may be at 71.8% percent. So almost 3/4 of women living with HIV have experienced trauma across their

lifetime, which I just think it's really staggering, and really should be informing the work that we're doing with folks who are living with HIV.

And with that, I'm going to pass it over to Surrabhi, who is going to talk more about the risk and vulnerability.

SURRABHI KUKKE.Hi, thank you, Kate. And thanks everyone, for attending this webinar. So we begin with the question about how gender-based violence increases risk for HIV and vice versa. There is this awareness that there is a back and forth relationship. And I want to invite participants, we're creating as many opportunities as possible to hear your experience and thinking. So please, take a minute and put your thoughts into a chat box. How do you see this bi-directional relationship manifesting? Reflect on your patients. Think about your own clinic setting. What it looks like. How does gender-based violence increase the risk for HIV and vice versa.

We may give it a minute to give you guys a chance to think and reflect and put some thoughts down.

STEVE: If you have thoughts, please enter them into the questions pane, and I'll read them out. We have one that says, victims have less power in the relationship.

SURRABHI KUKKE.Less power. OK, great. That's an important point that they have less power and power for what is the question. I think we can sort of move in that direction.

STEVE: We have another that says less likely to control sexual encounters with their partner.

SURRABHI KUKKE.You're moving in the right-- in the direction I was hoping. Thank you for your comments. First and foremost, gender-based violence, which is predicated on an inequitable relationship in the context of intimate relationships, results in compromised decision- making power, reduction in autonomy, self-determination, and specifically in the context of sexual health, is compromised sex negotiation, whether it's about sexual activity, condom use, other contraceptive use. HIV positive women and men who experience gender-based violence were also more likely to engage in unprotected sex, not because they want to necessarily, but because of reduced power, as one of our colleagues mentioned.

Women who have experienced gender-based violence are also more likely to engage in higher risk sexual behavior, including having multiple sexual partners, having passed STIs, reporting inconsistent or nonuse of condoms as I mentioned already, or having a partner with known HIV risk factors. These kinds of things are not necessarily about a woman deciding she necessarily wants to take those risks, but that her decision making capacity is compromised to the point that some of these risks are sort of less risk than the abuse she might she might endure or she's weighing the pros and cons.

Women with a high knowledge of sexually transmitted infections, meaning how to protect yourself, how it's transmitted, but were fearful of abuse were consistently less likely to use condoms the non-fearful women with low knowledge. So the fear is the factor there, the fear of

potential abuse. That women who are living in violent relationships are likely to weigh the consequences of their actions, and am I more worried about getting a sexually transmitted infection or am I more worried about potential violence of refusing sex or insisting on a condom? So making those very difficult decisions is a stressful thing and results in many different health outcomes as Kate mentioned earlier.

So in addition to not be able to make decisions because of fear, there is also a forced factor. Social coercion can look like a range of different experiences, from very subtle emotional coercion, sort of emotional blackmail, for lack of a better term, where using language like if you love me, you will x, y, z, or you won't interest on a condom, or if you're being faithful, so sort of emotional pressure, all the way to using physical force. So coercion can have a very complex kind of manifestation in a relationship. And it can result in intentional exposure to an STI or HIV, using HIV diagnoses as the threat itself to disclose or out the person if they have not yet disclosed to everyone in their lives. And instilling fear in the victimized person about what would happen if she were to become HIV positive. So you can see the ways that coercion and control can operate at many levels, in many directions.

So the added factor—there are studies and data that show that where gender-based violence is present, there is a higher rate of unprotected anal sex. There are a variety of reasons for this and it's important for us to acknowledge that anal sex can be part of a healthy sexual relationship, but it can also be used to degrade and individual, especially if there's no consent to that sexual activity. It can be used as a way to degrade the victimized person. So what you all probably know, being service providers in HIV sector in the clinical setting, is that unprotected anal intercourse with a highly efficient means of HIV transmission. And the important factor here is that when it's unprotected and nonconsensual, the rates of transmission are even greater.

So when we're talking about the presence of gender-based violence, sexual coercion or control or that kind of dynamic in a relationship, the introduction of unprotected anal intercourse increases the risk considerably. A complex point that I would love to hear people's perspective on, from especially folks who work in the clinical setting is that perpetrators of violence, people who are in their relationships using power and control as a way to exert authority or some kind of power in their relationship, abused perpetrators for shorthand, are more likely to engage in greater HIV risk behaviors, including condom nonuse or more specifically coercive condom nonuse, sexual infidelity or concurrent partnerships, sexual partnerships, more likely to have multiple sexual partners to be more specific, injecting drug use, and more specifically unsafe injecting drug use or sharing injecting equipment without cleaning or reusing old equipment, and unprotected intercourse.

The point that the studies have revealed that people who are more likely to perpetrate abuse in their relationships are also more likely to engage in HIV risk behaviors. So this is to say, when you have a female patient who discloses in one way or another that their partner and is being abusive or is coercive, in a whole range of ways across the spectrum of coercion and control, it's important to keep in mind that that abusive partner is also more likely to be engaging in risk behaviors, if they are not already HIV positive. So an important kind of lens through which to look at your patients and their lives.

When you think about risk, reducing risk for HIV, as you all know and I'm sure in your work around prevention of HIV and reduces risks, requires an individual behavioral change, that people need to make different kinds of decisions about own sexual activities and protection, methods of protection. When we talk about vulnerability, which we'll be getting into shortly in the next few slides, and we're thinking about marginalized communities that are increasingly vulnerable to HIV and gender-based violence, when we think about reducing this vulnerability, we're really talking about more structural social changes. Because the reason that people are vulnerable is because that stigma and discrimination that Kate mentioned earlier. That people who are stigmatized because of their behavior are people who are more vulnerable to HIV, STIs, as well as gender-based violence.

So the first vulnerable population I'd like to address is sex workers, women. In this case we'll focus on women briefly because much of the research has been done with women. Women involved in the sex industry, including those trafficked for sexual exploitation, suffer a high burden of HIV. This is a known factor. And I think any of you working in this field of HIV are familiar with this. However, it's important to remember that sex work, transactional sex, economically motivated sex not inherently a form of gender-based violence.

It's the power dynamic that's implicit in the exchange of sex for money, drugs, or other necessities that creates disproportionate vulnerability to violence. That when sex is being exchanged, the ability of the person in power to exploit that exchange is greater, and that the kind of violence from other perpetrators but not a fairly intimate partner, but especially for women involved in the sex industry is another layer, another factor that gender-based violence presents that is not common in everyone's lives. But when you think about the intersection gender-based violence and the burden of HIV, sex workers experience a very strong and powerful vulnerability in their communities.

And there is a significant overlap here between women who engage in sex work behaviors, trading sex for money, drugs, food, other necessities, and women who engage in injecting drug use, especially at the street level. Street level workers experience this overlap in particular. Many female injection drug users are also engaging in sex work, regularly or occasionally, which increases their risk of HIV transmission and women who are also injecting drug users have reported transactional sex. So this overlap, this intersection between injecting drug use and sex work, especially at the street level introduces another layer of vulnerability, exposure to multiple sex partners, limited condom use, and high threats of violence and high social marginalization.

So as providers, you have the opportunity to really think about how to integrate mental health services, addiction services, into your HIV service delivery program. Because the overlapping experience, especially for people who are living in poverty, living on the street, and struggling with many layers of marginality, the clinic where they come to for health care might be the most viable option for accessing services. So if it's not possible for you to provide these services, reach out, find out about the programs in your community that you can link them to. Building a tight web, tight net, of services that can really catch most vulnerable people in our community is going to be the best bet for stemming the epidemic, as well as meeting the needs of people living with HIV.

When we think about men who have sex with men-- again, I'm not talking about gay men, per se, self-identified gay men, I'm talking about a behavior, men who have sex with men, because vulnerability is not just about the behavior, it's about the stigma attached to the behavior. So many studies have shown that men who have sex with men that experience violence are more likely to be HIV positive when not experiencing violence. They are also more likely to engage in substance use and unprotected anal sex, again, potentially because of their inability to negotiate condom use and power in the sexual relationships. A study conducted in Alabama also reported the inability to negotiate condom use. The study was conducted with men who have sex with men who also experienced gender-based violence.

And I wanted to make sure that I had an opportunity to talk about transgender people living with HIV, not because their behaviors are necessarily different, but because they are such a vulnerable community, both for violence and for HIV transmission. And this is where the violence in this community's life is really driving exposure to HIV. Transgender women are impacted by physical and sexual abuse at extraordinarily high rates by many, many, many people in the community, not just intimate partners. They are also murdered at very high rates, experiencing violence at the hands of law enforcement and many, many other actors in their lives. So really seeing the way violence is driving the movement of HIV in transgender communities is going to be an important perspective.

Transgender women are also impacted by HIV at disproportionate rates, upwards of 30% and they are infected with HIV at over 4 times the national average. So to start seeing the intersection between sexual assaults and domestic violence and their HIV rates, becomes rather alarming, an important perspective. Again, though I want to highlight that this is not the same kind of vulnerability we're talking about, but it carries the transgender life experience caries stigma and discrimination that creates a vulnerability for them in our society that is important to pay attention to, that it is not about their individual behaviors.

We have a poll now and I really want to hear from you all about your experience with your patients, especially those of you who have clinical experience, experience with sexual of forced sex, physical abuse by an intimate partner, other kinds of trauma or PTSD. And by other trauma I mean childhood sexual abuse, incarceration, or violence by law enforcement or childhood exposure to violence, if not child abuse itself, witnessing a parent being abused, or all of the above, which unfortunately is often the case for people who have experienced or witnessed violence as children, unfortunately grow up to experience many other kinds of trauma.

So take a few seconds and please fill out this poll and we'll give it a chance.

STEVE: And we will show the results in a second here.

SURRABHI KUKKE. All of the above. I was debating whether or not to actually include that one, Because it was like I said, as we've learned from the Adverse Childhood Experiences Study, which has gotten a lot of press. And if you haven't heard of it, it's called ACES, the Adverse Childhood Experiences Study. I highly recommend checking out at least the Executive Summary. It gives you a really good picture of how experience in childhood have a long term

effect on people's ability to have healthy relationships or people's perspectives on what healthy relationships are and what can happen.

So this gives us a little window into how much trauma you are actually seeing in your clinics. And I want that to be impressed upon you, because violence, and in particular gender-based violence is a very under-recognized barrier to women's ability to obtain medical regular care. And this is an important access issue, because if we are not nothing the ways that violence exacerbates vulnerability, and we're not really mean taking that into account when we're thinking about treatment adherence, arriving on time for appointments or following up with a referral that you've given to a patient. If we're not paying attention to the possible barrier that violence is presenting, we will feel like this patient is just non-compliant. There's nothing we can do. And our own sort of hopelessness sets in we kind of throw our hands up and we're like, no, there's nothing I can do to help her. She's not helping herself. When there may be another layer that we need to consider.

From an access to care perspective, the fear of violence can itself prevent women seeking care. The fear of disclosure can be terrifying and paralyzing, frankly. Abusive partners can use HIV as a method of control. I've mentioned this already, that need to reveal status. Especially if there are custody issues in play, judges can look harshly on this information. It can be a humiliating piece of information. And you know, HIV status has also been used as an excuse for violence or abuse. You deserve this because you have HIV. And none of this is, of course, good, right, or correct, but unfortunately, this is an amalgamation of what has been experienced by people. And we're sharing the information you to give you a picture of how bad it can get.

Medication adherence, we know how important it is, especially to handle HIV progression. But for people living in violent relationships, this can be a great challenge, both from the perspective of medication interference, where partners can destroy medicines, throw it out, inhibit the patient's access to medicine and preventing her from getting it in the first place. And you know, for a woman or a person who's being victimized at this level, it might just be hard, like I mentioned to prioritize medicine or taking the medicine on time every day and all of it because there are so many other things she's juggling to kind of placate the abusive partner.

And then of course, the fact is that depression and post-traumatic stress disorder (PTSD) have been associated with low medication adherence, just a sense of hopeless, like it doesn't matter. I don't care. You know, nobody cares about me anyway, et cetera. Not reality, but really consistent to that profile of depressive symptoms that prevent medical adherence. And violence and trauma also are in and of themselves, barriers to viral suppression. Like we mentioned, it can compromise ART uptake and adherence, which relates to core treatment response. But the stress that violence and trauma increases can really accelerate HIV disease progression, which is likely due to compromised immune systems.

Stress, as a general experience, has so many sort of effects on the immune system generally, even without an immuno-compromised state like having HIV. But add HIV to that, the disease progression moves more rapidly. If you're interested in research on this, when you are able to download these slides, and notes on all these slides have extensive links to studies that elaborate on these points. At this point, I'd like to hand back over to my colleague, Kate, to start talking

about some of what you can do in your practice, especially when it's in the testing and counseling phase, be sure a patient has tested positive. So, take it away, Kate.

KATE VANDER TUIG: Thanks so much, Surrabhi. So, as Surrabhi said, we are going to be getting into what are the implications for all of this large context that we set for you all as you work as providers, specifically in HIV testing and care settings. And so before we get in to kind of what the implications are and what we're hoping you all are willing to take on, we just wanted to find out how many of you are already talking to your patients or your clients about how their relationship affects their health or are talking about domestic violence or intimate partner violence with your patients in any respect? So go ahead and fill out that poll.

STEVE: OK we'll take a minute here or so to answer the poll question. Please select a response, and then we'll share those responses in a minute.

KATE VANDER TUIG: Awesome. All of the answers to those questions make me so happy. It's so great to see that yes, a lot of you already talking to your patients about this, which is great. And then a lot of you are doing it most the time, some of the time. There's a question on your HR intake form or intake form about that's a screening question for domestic violence. So that's so great to hear that you guys are already doing this.

Now we're kind of going to give you some tools and strategies to be able to do this in a way that's both survivor patient centered, but it also makes your job a little bit easier. Because we saw there's so much prevalence of this happening, particularly with folks who are living with HIV that in order to really be addressing the health issues that folks are living with HIV has, we also have to be addressing the trauma in their lives. So the main approach that we are seeing be successful, not only in HIV programs, but really in all health settings, is a move away from using just one or two screening questions about, have you been hit, kicked, slapped, or punched, to a more universal education approach.

This approach is basically just more successful than just a screening question or just a couple of screening questions because it really goes far enough to reduce isolation of survivors and patients and increase their self-determination. And knowing that one in four women are experiencing it and it's higher in populations who are living with HIV, then why not? Why not talk to all of your patients about how [? granting ?] violence can affect their health and that there are resources out there for them to utilize.

So you always providers have just a really important role. One study showed that women who are talking to their health care provider about the abuse were four times more likely to use an intervention like calling a domestic violence hotline and 2.6 times more likely to exit the abusive relationship than if they had not gotten this information from the health care provider. So you play such a unique, specific, and important role. So many more people are going to their health provider for their HIV medicine, for their well woman visit, et cetera, who will never necessarily of their own accord, call a rape crisis or domestic violence hotline or reach out to other services about what's going on in their relationship, because they might not even recognize it as something that's connected to their health and that they need to be addressing. So you all are

really just playing such an important role, especially when you're validating and empowering survivors. You're seen as a trusted resource.

And not only is your role very important, but it's also very much doable. You do not have to be an expert in gender-based violence in order to have a conversation about it with your patients. You can connect to local, domestic, and sexual violence agencies to really kind of step in to be that expert, to fill that role. And you're kind of that person who has the initial conversation and the connector. And then the HIV testing and counseling opportunity offers a confidential, private, and unique space for education, early identification, and risk reduction intervention.

And a lot of barriers that we hear from providers who are initially starting to think about talking to their patients about violence is like, I definitely want to, but it takes time, which is true. It is a conversation. But in the long run it is saving time because you are addressing the underlying causes of many health issues that you might not have already otherwise been addressing and those health issues might have been persisting.

Another barrier we hear is that it's uncomfortable. It's uncomfortable to ask people about their relationships. And I would just say, I think that you all, particularly this group of folks who are in this webinar, that might not be a barrier because you already talking about sex. You're already talking about relationships with their partners. And so I would just challenge you to say, that it probably isn't as uncomfortable with you all and to push you to start meeting patients where you're at. Sounds like a lot of you are already doing this, so that's wonderful.

And then as I mentioned, we're really kind of moving away from just a checklist format, something that gets filled out and goes into a chart somewhere and no one ever responds to, to be more of a conversation. It's how this clinic is set up and it's how providers are trained. So moving away from the focus on screening questions to universal education, assessment, and brief counseling or support. Studies show that patients actually do really want their providers to talk to them about violence they are experiencing, especially like validating that they are experiencing something and that they have options to do something about it.

The patient-centered approach addresses concerns about how information will be used, particularly health records and reporting. It's empowering patients with information, regardless of whether they screen positive, et cetera. And just being aware of the mistrust of health care providers, the mistrust that some patient communities have of health care providers, just because the legacy of discrimination and inequitable care. So just to note that though there are many validated tools for screening for domestic violence, that there's not one perfect set of questions or one perfect question that's going to increase disclosure rates. We often hear that there's a big focus on increasing disclosure rates or this was really successful because so many more people started to disclose. But we want to challenge you all to kind of move towards thinking of, you know, the goal is not to increase disclosure rates, but it's really to provide as many patients with information they need to make decisions about their lives with regards to their relationship as possible. It's about empowering patients.

So here's kind of the steps of our intervention. We're first asking folks that they disclose limits of confidentiality, that they do the normalizing universal education piece, and then the follow up

with finding out how the patient's relationship is going. And then if there is any support that needs to be given, to offer it in a way that reduces harm and is nonjudgmental and validates their experiences. And then if they're interested, making a warm referral to someone that can kind of follow up with what's going on with them.

So assessing for gender-based violence can put your patient at risk, if you're not doing the assessment or the conversation by themselves. So we always say, talk to patients about violence alone, not in front of other people, always disclosing limits of confidentiality before the assessment and never-- I'm sure you guys already know this-- never using a family member as an interpreter or a friend, as an interpreter. And then just to note that there is a violation of HIPAA reporting laws if you were to report something that wasn't mandated that you report by law.

And in order to be inclusive for all patients, and I think this is stuff you all are probably already familiar with as well, being sensitive to the fact that folks who are queer, LGBT, who are requesting HIV services might also be in abusive relationships, using gender neutral terminology when referring to their partners, recognizing that folks who are LGBT might not identify as such or tell you that they are LGBT. And that is OK. And being aware of the LGBTQ resources in your community, so that you're able to connect to someone to more culturally specific resources really makes extra difference and kind of furthers the relationship of trust between you and the patient.

So we often hear from providers, I really want to talk to my patients about violence, and I really want to get involved in this, but what do I actually say? So we're going to give you some scripts and also talk to you about a tool that many providers are using that is essentially a script in and of itself. So, here's a sample script for disclosing limits of confidentiality we know some providers are using. And just to underline that this was specific to one state, but that you should definitely look up the mandatory reporting laws in your specific state because it is different state by state.

So Futures Without Violence has worked with several partners to develop an evidence informed tool for providers to use with patients that actually makes the conversation about violence and relationship much easier. The tool is something we call the safety card and we have many safety cards for different health settings. And we have developed one specific to HIV testing. And we are currently working on one that is specific to HIV treatment and care for folks who are currently living with HIV.

This card is really a conversation starter, or prompt and guide and works as patient education. It's helping survivors of violence learn about safety planning, harm reduction strategies, and support services, and can also be a tool to plant seeds for those who are experiencing the abuse, but not yet ready to disclose to you about it. And it in turn is also providing primary prevention for patients who are not in any kind of abusive relationship, but they maybe would start to identify the signs of an unhealthy relationship and ideally avoid those relationships.

This card, I know you all are-- we're on a webinar so I can't hand one to you right now, but it's a nice easy, fold up, accordion style that fits in a wallet or in a shoe, or in a cell phone case, and can be easily disclosed. We always tell providers to go over it with the patient. Tell them that

they're giving the card. This is never something you just want to throw into a packet without telling the patient that it was there. And then also to give them too, because we hear so many stories of survivors who come back and say, you know, like, can I get another one, because I ended up giving the one you gave me to my friend who is experiencing abuse. So this goes farther than just the visit with you and your patient, because they can share that material with their friends. And just also highlight a safety note, that you'll notice that there's nothing on the front that says domestic violence or violence or anything like that. So we tried to keep it relatively innocuous in terms of that.

So in order to introduce the safety card, though most victims of gender-based violence, survivors are women, we would like to say that just for this population it's good to have the conversation with all clients, regardless of gender, age, or other demographic characteristics. It can be most helpful to connect the card to the visit by saying something like, because violence impacts relationships and relationships is so common, and can have serious health impacts, I give this card to all my patients. Let's take a look at it. It's kind of like a magazine or online quiz. It talks about respect and sex and how those things are connected to STIs and HIV. Unhealthy relationships, as you may know, can affect people's health and also put them at risk for HIV or put them at risk for other STIs and there are options for folks in our community if they are needing them.

So here's the first panel of the safety card. And you'll notice that it kind of starts out on a positive note, you know, which is a really good entry point into talking about it. People get tested for all sorts of reasons. And then it goes through some reasons why folks may be in your office getting tested today. And it also just kind of ends on a note of empowering. You know, it sounds like you're making decisions about sex, which is what you deserve. And then it also goes on to have some more direct questions. Does your partner ever make you feel afraid or threatened and other questions that are helpful to kind of get more information about what is going on in your patient's relationship and how it might be affecting their health. It's helpful for providers to communicate that patients don't have to answer the question if they're uncomfortable and the reason they're asking is not because of them, it's something that you talk to all of your patients about, so normalizing it.

So this panel on the card gets at sexual autonomy. And if that's something that you were hoping to talk to your patient about because you felt like it was a part of what they might be experiencing in their relationship, you might use this panel to do so. And it also comes back to normalizing it. You know, if you answered yes to these questions, you're not alone. See the back of this card for numbers to get more information about being judged.

This panel of the card talks more about risk from partners and ways that people who are experiencing violence, trauma, and/or just have HIV, might be using coping mechanisms that aren't healthy, like substances to cope with the pain, and just also normalizing that. And that is common, and there are people who can support you around this and there's more information on the back of this card.

And then I'll pass it right over to Surrabhi who is going to talk a little bit more about specific opportunities to bring up the discussion of gender-based violence. On

SURRABHI KUKKE: Thanks, Kate. So, in the context of HIV testing, there are so many opportunities to introduce this discussion. And like Kate, I'm delighted to hear that the vast majority of you who responded to that poll are already talking about this at one point or another. And it makes sense. I think that the HIV epidemic has exposed so many ways that power plays out in people's relationships that it makes perfect sense that you are already tuned into this. I hope that today we are able to give you a lot more meat on the bone of what you know and provide you some resources.

So the safety card can be introduced in a variety of ways and a variety of places. But the significant thing to think about is connecting into the reason for their visit, with a reason for the conversation that you're having in the moment. So some other moments might be you're at intake or pretest counseling during risk assessment in your counseling process or when you take a sexual history, during discussions of a reaction to the test results. Because that might be the sharpest indicator for you, like a terrified patient. Someone who's experiencing a lot of fear about disclosing test results to a partner is a good red flag that that might be happening there. And then certainly in post-test counseling, during safer sex discussions.

It's highly recommended to integrate a GBV assessment into pretest counseling. I think that this is pretty much standard practice at this point. So we invite you to consider trying it out the safety card in that process. If asking about the nature of relationship or the health or the status of the relationship is already your practice, think about using the safety card as the vehicle for that and see how it goes.

I have a number of scripts here, but in the interest of time and because I know you have access to these slides, I'm not going to go into great detail reading all these scripts. But I know that you go back to these slides and take a look at them and see what you might integrate into your own practice when it comes to pre and post-test counseling. And during pretest counseling integrating GBV assessment really allows the client to consider these consequences. It enables providers to anticipate the need for support and offers an opportunity for an intervention, even if the test is negative. So the fear that you might witness about the potential disclosure might be enough information for you to provide some support access, some services, and the safety card could be a tool, a vehicle for that kind of communication.

And you know, it creates an opportunity to have a discussion about violence, but separate from learning HIV status. Because once a positive-- even if it's another STI, once the positive status is disclosed, the mind go blank. I'm sure those of you who have had to do pre and post-test counseling know that once HIV status is disclosed or even other STIs, it's hard for the patient to think about or talk about anything else, because it's such a earth shattering revelation for them. So having this conversation at the front end really enables some dialogue to happen at least if they're open to it or interested in pursuing that discussion before any other discussion around HIV status.

Post-test counseling also provides additional opportunity, really when you're talking about party notification, but of course, should happen before any partner names are elicited for confidentiality purposes. So again, I have script embedded in these slides, but in the interest of

time, I'm not going to go over the scripts per se. And I invite you to take a look at these slides later to see what will work.

Because we know that people can have multiple partners at the same time or consecutive partners, it's important for balance assessments to take place on a partner by partner basis for partners who are voluntarily identified. Because following up, exploring a history of domestic violence, or intra partner violence, or other gender-based violence and its anticipated consequences of HIV partner notification, it's that intersection that will get tricky. To find out about all the people that the patient might need to communicate with, it's important to also find out about each of those people if there was a history or a risk of a violent response. Are you afraid of what might happen to you or someone close to you if this partner was notified?

So getting some information in the pre-test and during the risk assessment phase of the partner notification phase of post-test counseling is going to be very, very important. And remember disclosure in and of itself is not the goal. We're not trying to get people to disclose, but at the same time, disclosures happen even when you're not explicitly asking for it. So this is like a place where it's rife with complexity. People are talking about their life and are thinking about all the layers of their fears and anxieties and information may emerge that it will be important for you to keep in mind.

And this is why it is so important to begin with universal education. Survivors should not have to disclose in order to get important and helpful information about the way that their relationships affect their health and there are resources that are available. And at the same time, disclosures happen when we least expect them. And it's important for you as providers to know what to do and how to respond to them.

So in that interest, it's important to support survivors by listening and validating. Thank them. You know, remember that it is a privilege as a provider for you to have been considered safe and trustworthy enough to share this extremely sensitive information. Thank them for sharing this with you and convey empathy in whatever way makes sense for you. Validate that gender-based violence, sexual coercion, these are health issues that you can help with, with referrals or other kinds of support. And let them know that you can support them without any judgment.

I'd love to hear from you since so many of you have been able to incorporate these discussions, what are some validating statements that you have used in your experience that work to help people feel your empathy and connection? Please, I invite you to type them into the chat box and Richard can read them off to us?

STEVE: OK, if you have any experiences, you can enter them into the questions pane, and I'd read them out here. I'm not seen anything right now.

SURRABHI KUKKE: Nothing? People feeling shy? You're a mighty quiet group, but we'll go on in the interests of time. Some validating statements that work well, that can be straightforward, and again, this can be revised to be natural to you. I'm glad you told me about this. I'm so sorry this is happening. No one deserves this. You're not alone. Help is available. I'm concerned for your safety.

Your recognition and validation is invaluable. Just remind her that there are alternatives. There are different ways. And it's important to highlight what you want to avoid saying. You definitely don't want to say, you should call the police and make a report. It takes so much courage for people to reach out and say something about their experience of violence, that we want to try to be as nonjudgmental as possible.

To kind of name the abuse, you are definitely in an abusive relationship really takes it the power away from the victimized person. Or to deny it, to say, that doesn't sound like rape to me if she herself or your patient has identified herself as being a survivor of rape. Or to criticize the partner, your partner's crazy. You need to break up with them, tell them what to do, again takes the power away. Speaking badly about an abuser is another way of being judgmental of them, about why they're there, or what have you.

So trying to really focus on keeping the power in the hands of this patient, letting them decide how much information to disclose, just validating what they offered, and appreciating their strength and courage to share it is where you want to say. And definitely not to pry for more details than what they are willing to offer. So what happened after that, what happened after that? There's no need for providers to know more than they offer in order to be supportive.

What the providers need now is that there is a situation, and this patient needs some information about harm reduction. So one place harm reduction can happen is around safer partner notification. You can either use this panel on the card as a way to move in that direction or you can just share information about anonymous partner notification, some online options for disclosing status anonymously, but helping the patient figure out a notification plan that works best for them, and also at the same time, providing resources to do safety planning.

HIV partner notification can itself spark an abusive reaction. Other negative outcomes that may occur include things like losing housing, withdrawal of friendship support, custody retaliation, or access to health care, medication, especially if they were on their partner's insurance. And it's important for you to know your state specific laws regarding partner notification, which I expect that you all are very versed in. But consider the harm of partner notification if your patient is in a violent relationship.

Another approach, if this is an option in your state is deferral of partner notification. And of course, confidentiality is of utmost importance. And when it's related to HIV and gender-based violence, the confidentiality features much more strongly. The protected information will be used only to make decisions about whether partner notification should proceed and how other referrals can be provided. And of course, in no way, in no cases should names of HIV positive folks be provided to partners directly by public health staff. So there have to be assurances made your HIV patients that are also experiencing gender-based violence, that you are a safe place for supporting these patients living with violence.

And finally, providing a warm referral, if it is possible at all at your clinic to build a stronger relationship with your local domestic violence program, this just means finding a name, a person that you can directly connect your patient to, a local advocate that can either come to the clinic or get on the phone with her to come up with a plan to protect her safety, that is the best, warmest

way you can provide a referral. Another warm referral option is to look at the resource panel at the back of the card. There are some excellent resources, phone numbers, websites that people can access safely to identify options for safety planning.

The National Domestic Violence Hotline is an excellent place, and I encourage each of you who provide services to call that hotline. Tell them that you're calling from a health center and ask them what kind of service do they provide when a woman calls the hotline. You'll get a picture of the kind of depth of safety planning services that are offered, the number of languages that are available, and it will enrich your ability to provide a warm referral to a patient. I really encourage each and every one of you to call that National Domestic Violence Hotline and get a sense of the services that they provide on there.

When you're using the safety card, if there's no other thing that you do than to tell her what the safety card is about and show her the back panel, that is at minimum, the most valuable service that you can provide in your clinical setting. And the last two slides, I just want to highlight, currently with HRSA partners, Futures Without Violence is conducting a pilot project called Improving Health Outcomes Through Violence Prevention. And it's using this kind of brief counseling for intimate partner violence in health centers to improve health outcomes for women and also integrate relationships between health centers and domestic violence programs across the United States.

So the core elements of this pilot with programs just like yours, health centers just like yours, is to educate providers on the impact of IPV and health outcomes, promote education for patients, institutionalizing into your program policy, and educating advocates in the community on this connection between violence and coercion and health. Just to give you a little picture of how broadly this is happening, in health centers just like yours, this is a little map of the participating sites for this pilot study.

So like Kate mentioned, this is totally doable, and it has a broad application in many different kinds of health studies and has been taken up for the past 25 years through study participants and clinics across the country to enhance the way that they do-- to move from screening to universal education, direct assessment and warm referrals, with harm reduction counseling. And really provide a patient-centered approach to care and understanding health outcomes through a balanced end. So with that, I take my final slide. Thank you for your participation.

I want to open it up for questions and also point you in the direction of the CME evaluation here, as well as a website that we have that the National Resource Center on Health and Domestic Violence manages called Health Cares About IPV. It's a place where you will find a wealth of information, including a way to order these safety cards, as well as posters and other tools that are available virtually free of charge. I want to tell you that the tools that are available on this website are free of charge. You're only charged for some shipping, which is a very nominal fee.

And if you'd like to receive materials, I invite you to contact Kate Vander Tuig directly. There are other ways to access through the website, but because you've participating on this webinar, we want to invite you to have a direct line to accessing it. And please type in your questions in the Q&A box. We'd really love to take the last 10 minutes fielding any questions you have about

the intersection between HIV and gender-based violence, the use of the safety card as the response tool, and also any other resources that we have available.

STEVE: OK, we have a few moments here. We can take some questions. We did have a few comments that came in and are interesting. One person said, unable to advocate or protect themselves because requesting the use of condoms for safer sex may cause the partner to accuse them of going out of the relationship and potentially put them in danger of physical abuse.

SURRABHI KUKKE: Absolutely. This is exactly the kind of-- this illustrates the kind of dilemma that victimized people might be experiencing, where they have to weigh the consequences of exposure to an STI or an unwanted pregnancy with the exposure to violence because of this assuming infidelity. And understanding and being sensitive to those nuances in relationships for people who are experiencing violence is going to be an essential way to provide a connection to safety planning and harm reduction.

One of the ways that we talk about it in reproductive health is providing sort of invisible methods of birth control if pregnancy is the primary concern. When it comes to HIV, protecting oneself from HIV, increasingly there's a perspective on the use of [INAUDIBLE] for people living in abusive relationships. It's not clear that this is ideal because of the importance of very strict adherence. But it's something that is being explored either invisible methods of protection like microbicides have not shown to be as robust in terms of their ability to protect, but there needs to be more research in this arena for sure. Because vulnerability to violence sometimes will trump their sense of risk, or even how much they care about their risk of HIV or other STIs, you're absolutely right.

Any other feedback on that or thoughts? I invite people to respond to that as well.

STEVE: We had another comment. There's also the abuse received by trans people inside the prison systems. Not enough is being done to highlight and protect them there.

SURRABHI KUKKE: Kate, do you want to comment on that?

KATE VANDER TUIG: I was just, yes, agreeing.

SURRABHI KUKKE: We absolutely agree. I think the discussions around the health of incarcerated populations, people living in the prison system, barely surviving int the prison system is one that we need to be having much more dialogue about. I think that there is some interesting conversation, or maybe it's one-sided at this point and not really a conversation, about how to create safer environments. But that is a huge factor in the experience in HIV prevalence in trans communities is violence everywhere absolutely. Thanks for highlighting that detail.

STEVE: If anyone else has any questions, please enter them now. We had one that actually came in a while back and maybe referencing something else, but the question was is HIV still considered a disease predominantly affecting men?

SURRABHI KUKKE: Well, in the United States, if we speak globally, no. Globally women are disproportionately affected by HIV. In the United States, however, the numbers still show that men in particular, men who have sex with men, and black gay men, in particular, having highest rates of HIV transmission. And young black men being the highest of that. That said, the rates of transmission among women is increasing. And though I guess the rate at which women are becoming HIV positive is increasing rapidly, and in particular, women of color, black women, because-- I can't say because, because there reasons are more structural. They have a lot more to do with vulnerability because lack of power, both socially and in relationships.

But because HIV is no longer-- is, I guess one can say, in the United States people can live for long periods of time with HIV if they're able to adhere to their medicine, women are dying because of their inability to adhere to medicine or the late stage at which they're being tested and or tested positive. So there are many factors that show the rates at which-- well, there are many factors that reveal why women might be dying of HIV related complications more than men. But men still are the majority of people infected with HIV. I hope that was clear. I think I kind of stumbled on that one.

And I invite your peers to comment on that as well. I imagine there are many people on this call that have a lot of knowledge as well, on prevalence of incidents.

STEVE: OK. I'm not seeing any more questions right now. We'll give folks a minute or so, if you have any further thoughts.

SURRABHI KUKKE: Well, if there aren't any other question, I just want to thank, on behalf of Futures Without Violence, thank all the folks, P4C and HRSA for inviting us to participate in this. It's really exciting to know the breadth of the interest in this discussion. And we hope to be able to provide support to you and your colleagues in future.

So definitely stay connected with us through our website, through our email address. And use our resources and give us feedback on how it goes. Let us know. Drop us a line. If you start using those safety cards and you find that anything about the language or the visuals, or any aspect of it. We're open to hearing feedback. We really, really invite it. Thanks so much for your time and attention.

STEVE: OK. Thank you for participating in today's webinar. We hope that you were able to find the information provided useful as you continue your P4C project. Thank you again for participating in today's webinar. And thank you, Ms. Kukke and Ms. Vander Tuig for that excellent presentation. If you have any additional questions for the P4C project or for our presenters, please email us at p4chivtac@mayatech.com. Take car everybody and we'll see you next time.