Violence Against Women and HIV: global perspectives

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One in three women will experience physical or sexual violence
Intimate partner violence (IPV) is most common form of VAW globally

Proportional Venn diagram depicting overlap of types of violence among 24,000 women interviewed as part of WHO multi-country study on domestic violence and women’s health

Adapted from Heise: WHO Multi-Country Study on Domestic Violence and Women’s Health
Past year levels of intimate partner violence vary widely.
Findings from cross sectional studies on a link between IPV and HIV are conflicting

• Many published studies have methodological issues that limit the robustness of their findings

• Most recent meta-analysis finds an association between biologically confirmed HIV and IPV, in 12 DHS surveys from sub-Saharan Africa

• In multivariate analysis, the association remains significant only in settings where >5% of adults are HIV positive
Violence against women is associated with incident HIV infection

1. Physical IPV and HIV infection among women

<table>
<thead>
<tr>
<th>Cohort studies</th>
<th>Weight</th>
<th>Risk Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kouyoumdjian, 2013</td>
<td>8.1%</td>
<td>1.18 [0.95, 1.47]</td>
</tr>
<tr>
<td>Van der Straten, 1998</td>
<td>5.7%</td>
<td>1.32 [0.93, 1.86]</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>13.8%</td>
<td>1.22 [1.02, 1.46]</td>
</tr>
</tbody>
</table>

Total events
Heterogeneity: Chi² = 0.27, df = 1 (P = 0.60); I² = 0%
Test for overall effect: Z = 2.13 (P = 0.03)

3. Any type of IPV and HIV infection among women

<table>
<thead>
<tr>
<th>Cohort studies</th>
<th>Weight</th>
<th>Risk Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jewkes, 2010</td>
<td>3.0%</td>
<td>1.52 [1.05, 2.20]</td>
</tr>
<tr>
<td>Kouyoumdjian, 2013</td>
<td>3.8%</td>
<td>1.18 [0.96, 1.45]</td>
</tr>
<tr>
<td>Were, 2011</td>
<td>2.8%</td>
<td>0.91 [0.59, 1.38]</td>
</tr>
<tr>
<td>Zablotska, 2007</td>
<td>2.6%</td>
<td>1.80 [1.13, 2.88]</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>12.2%</td>
<td>1.28 [1.00, 1.64]</td>
</tr>
</tbody>
</table>

Total events
Heterogeneity: Tau² = 0.03; Chi² = 5.93, df = 3 (P = 0.12); I² = 49%
Test for overall effect: Z = 1.96 (P = 0.05)
Associations not only between violence and HIV, but also with unequal relationship power

Incidence and relative incidence of HIV infection, by exposure to forms of violence and inequity

<table>
<thead>
<tr>
<th>Relationship power†</th>
<th>Number of seroconverters</th>
<th>Person-years</th>
<th>Incidence (per 100 person-years)</th>
<th>IRR (95% CI)</th>
<th>HSV2-adjusted IRR (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium or high equity</td>
<td>73</td>
<td>1334.7</td>
<td>5.5</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Low equity</td>
<td>51</td>
<td>601.3</td>
<td>8.5</td>
<td>1.55 (1.08-2.23)</td>
<td>1.54 (1.07-2.22)</td>
</tr>
<tr>
<td>Physical or sexual intimate partner violence‡</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None or one</td>
<td>83</td>
<td>1607.7</td>
<td>5.2</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>&gt;1 episode</td>
<td>45</td>
<td>469.0</td>
<td>9.6</td>
<td>1.80 (1.24-2.59)</td>
<td>1.69 (1.17-2.46)</td>
</tr>
<tr>
<td>Rape by a non-partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>121</td>
<td>1973.3</td>
<td>6.1</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Rape by a non-partner</td>
<td>7</td>
<td>103.4</td>
<td>6.8</td>
<td>1.11 (0.52-2.38)</td>
<td>0.98 (0.46-2.11)</td>
</tr>
</tbody>
</table>

Source: Jewkes, Lancet 2010

- 23% physical or sexual IPV, 5% rape by non-partner
- IPV more frequent in unequal relationships (29% vs. 22%)
- Rape not associated with incident HIV

- Increasing evidence for the associations between physical violence, verbal abuse, and male controlling behaviours (Kouyoumdjian, 2013; Durevall, 2014)
IPV and HIV share many common features

- Both are endemic at high levels in many parts of the world, especially in East and Southern Africa.
- Both are spatially distributed, with “hotspots” and pockets of high and low exposure scattered in close proximity.
- Both disproportionately affect young women, especially in sub-Saharan Africa.
- Both share common “upstream” factors—such as insecure livelihoods, alcohol availability, rigid gender norms—that drive downstream risk.
Evidence suggests that multiple pathways (structural, behavioural & biological) behind VAW-HIV link

**Structural Drivers of HIV and Intimate Partner Violence**
- Poverty and economic stresses
- Gender inequality and social norms condoning use of violence
- Social constructions of masculinity and femininity

**Intimate Partner Violence**
- Woman experiencing violence
- Man using violence

**Psychological Distress**
- Chronic anxiety
- Depression
- Post-traumatic stress disorder
- Substance use

**Man’s Childhood Exposure to Violence**
- Clustering of HIV risk factors among perpetrators
  - Binge drinking
  - Concurrent partners
  - Purchasing of sex

**Increased Sexual Risk**
- Re-victimisation
- Multiple/concurrent partners
- Transactional sex
- Sex work

**Biological**
- Inflammation and immune activation
- Genital trauma
- Reduced access to information and HIV prevention
- Unprotected sex
  - Low adherence
- Higher likelihood that male partner is HIV positive

**Increased Likelihood that Woman Acquires HIV**
Sexual violence does not appear to be a key driver of the VAW/HIV link

• Individual women can become infected through rape, but with rare exception, studies do not confirm an association between forced sex and HIV (Winters et al 2015; Duverall and Lindskog 2015)

• The most important driver of HIV risk among women is the HIV status of her sexual partner.

• Since most forced sex takes place within on-going relationships, repeated exposure to an HIV positive partner probably influences HIV risk more than any “added risk” posed from genital trauma
Mental trauma and stress may prove important

Physical and emotional abuse is associated with up/down regulation of women’s genital immune response

- Women who experienced IPV were at increased risk of acquiring HIV with increasingly severe violence associated with increased risk of infection.

- Higher rates of depression and lower T-cell function in women who experience chronic abuse.

- PTSD associated with dysregulation of cortisol pathways—the fight or flight response (Delaney et al. 2013).
Fear of violence reduces **willingness to test**
Anticipated violence lengthens time to **linkage to care**
History of physical or sexual IPV decreases **ART uptake**
Current IPV is linked to poor **ART adherence**
GBV associated with poor **HIV outcomes**
Lower CD4+ counts, increased virologic failure and **OI**
What does the evidence suggest?

- Current evidence suggests that clustering of risk behaviours among men, is one of the most important pathways linking IPV and HIV in women.

- This suggests that HIV programes should focus both on risky behavior among men (e.g. violence as marker for HIV risk) and upstream structural factors that link both to IPV and HIV:
  - Gender inequality and gender norms condoning male dominance & female subordination
  - Binge drinking and availability of alcohol
  - Insecure livelihoods;
  - Acceptability of violence in relationships
VIOLENCE IS NOT INEVITABLE
SASA!: Uganda

**Start**

- Learning about the community
- Selecting Community Activists
- Fostering ‘power within’ staff and community activists

**Awareness**

- Helping activists gain confidence
- Informal activities
- Encouraging critical thinking about men’s ‘power over’ women

**Support**

- Strengthening skills and connections between community members
- Joining ‘power with’ others to support change

**Action**

- Trying new behaviors, celebrating change
- Fostering the ‘power to’ make positive change

Involving community members, leaders and institutions to build critical mass
Trial conclusions

- **SASA! had significant community impacts on:**
  - Attitudes towards the acceptability of violence & women being able to refuse sex
  - Past year occurrence of physical violence among those with a history of violence (52% lower, significant)
  - Levels of sexual concurrency reported by men
  - Women’s reported ability to refuse sex

- **Promising community impacts on:**
  - Community responses to women experiencing violence
  - Overall levels physical violence (52% lower, not significant)
  - New occurrence of violence in relationships

- **Direct intervention exposure not necessary to achieve benefits**
  - Cost approximately $1 / day per activist supported
Pathways of impact on physical IPV

DECREASED IPV
- Prevent new cases occurring
- Prevent old cases continuing

COMMUNITY

INDIVIDUAL MAN

Male attitudes about acceptability IPV; right of women to refuse sex

men’s expectations about men’s & women’s role in relationships

Men’s disclosure about use of violence

Levels of heavy alcohol use

INDIVIDUAL WOMAN

Attitudes about acceptability IPV; right of women to refuse sex

Women’s expectations about men’s and women’s role in relationships

Women’s disclosure of IPV/help seeking

RELATIONSHIP

Improved communication

More equitable distribution of power; less rigid expectations about gender roles

REDUCED IPV

Reduced concurrency/suspicion of infidelity

Normative attitudes
Influence community responses; individual’s attitudes (about IPV, gender roles, relationship dynamics, sexual concurrency); individual’s behaviours (men fearing repercussions, women feeling able to seek help)
SHARE trial reduced both HIV incidence, and physical and sexual IPV as reported by women

Effectiveness of an integrated intimate partner violence and HIV prevention intervention in Rakai, Uganda: analysis of an intervention in an existing cluster randomised cohort

Jennifer A Wagman, Ronald H Gray, Jacquelyn C Campbell, Marie Thoma, Anthony Ndyanabo, Joseph Ssekasanzu, Fred Nalugoda, Joseph Kagaayi, Gertrude Nakigozi, David Serwadda, Heena Brahmbhatt

Summary

Background Intimate partner violence (IPV) is associated with HIV infection. We aimed to assess whether provision of a combination of IPV prevention and HIV services would reduce IPV and HIV incidence in individuals enrolled in the Rakai Community Cohort Study (RCCS), Rakai, Uganda.

Methods We used pre-existing clusters of communities randomised as part of a previous family planning trial in this cohort. Four intervention group clusters from the previous trial were provided standard of care HIV services plus a community-level mobilisation intervention to change attitudes, social norms, and behaviours related to IPV, and a screening and brief intervention to promote safe HIV disclosure and risk reduction in women seeking HIV counselling and testing services (the Safe Homes and Respect for Everyone [SHARE] Project). Seven control group clusters (including two intervention groups from the original trial) received only standard of care HIV services. Investigators for the RCCS did a baseline survey between February, 2005, and June, 2006, and two follow-up surveys between August, 2006, and April, 2008, and June, 2008, and December, 2009. Our primary endpoints were self-reported experience and perpetration of past year IPV (emotional, physical, and sexual) and laboratory-based diagnosis of HIV incidence in the study population. We used Poisson multivariable regression to estimate adjusted prevalence ratios (aPRR) of IPV, and adjusted incidence rate ratios (aIRR) of HIV acquisition. This study was registered with ClinicalTrials.gov (NCT00334035). 

Results Among 11 448 individuals aged 15–49 years (5337 in intervention group clusters and 6111 in control clusters) enrolled in the RCCS, 5337 received SHARE and 6111 received standard care. SHARE intervention groups had fewer self-reports of emotional, physical, and sexual IPV at baseline and follow-up compared with control clusters (aPRR 0·80, 95% CI 0·67–0·94; aPRR 0·87, 0·79–0·96; aPRR 0·87, 0·78–0·98). SHARE intervention groups had lower HIV incidence compared with control clusters (aIRR 0·67, 0·57–0·78; p<0·0001), and reduced some forms of IPV towards women and overall HIV incidence, possibly through changes in social norms and behaviours.

Conclusion SHARE could reduce some forms of IPV towards women and overall HIV incidence, possibly through changes in social norms and behaviours.

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SHARE TRIAL’s Approach

- The Safe Homes And Respect for Everyone (SHARE) Project: 2005-2009
  - Community-based mobilization to change norms around IPV and offer integrated violence and HIV prevention programming
  - Screening and brief intervention to address IPV in the context of HIV testing and counseling
Other evaluations demonstrating reductions in incidence of HIV and/or IPV

- IMAGE Trial (South Africa)
- Various cash transfer trials
- Stepping Stones Trial (South Africa)
- REAL Father’s Initiative (Northern Uganda)
- SwaKoteka Trial with One Man Can campaign (South Africa)
Conclusions

• Findings highlight need to implement programmes proven to reduce violence and improve HIV outcomes on a wider scale
  
  — DREAMS is attempting this

• Tackle shared risk factors — will deliver multiple impacts

• Prioritise “hotspots” where IPV and HIV incidence are high

• Explore opportunities to integrate HIV into VAWG programmes and vice versa