LINKING SEXUAL VIOLENCE TO HIV RISK

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OBJECTIVES

- Describe the link between sexual violence and risk for acquiring HIV.
- Recognize whether internal stigma exists within your practice regarding
  - HIV and sexual violence
- Apply knowledge of HIV and sexual violence to your patient population
  - inclusive of LGBT (lesbian, gay, bisexual, and transgender)
- Evaluate how your practice setting assesses sexual violence and HIV risk.

Before we begin

While this presentation addresses the often difficult topics of sexual violence and HIV, it is not meant to diminish our family members and friends who are faced with these concerns daily…

NATIONAL SEXUAL VIOLENCE STATISTICS

- RAPE: Completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration

- WOMEN - Nearly 1 in 5 (18.3)
  - 51% raped by an intimate partner
  - 40% raped by an acquaintance

- MEN – 1 in 71 (1.4%)
  - 52% raped by an acquaintance
  - 15% by a stranger

► National Intimate Partner and Sexual Violence Survey 2010

SEXUAL ASSAULT IN INDIAN COUNTRY

- The magnitude is difficult to assess due to
  - Difficulties in obtaining solid statistics
  - Lack of uniform data collection
  - Failure to report the crime, and
  - Variations of reporting sexual assault
    - Law enforcement
    - Advocacy program
    - Health care provider

FACTORS AFFECTING REPORTING

- 70% of rapes are not reported, with higher rates unreported by Native Americans
  - History of social and personal oppression
  - Mistrust of government agencies
  - Fear of family reaction
  - Fear of retaliation
  - Lack of faith in the legal system:
    - Justice, reprisals, and lack of follow-through

▶ Gonzales 1999

PREVALENCE

- DESPITE DIFFICULTIES WITH GATHERING DATA AND ACCESS TO CARE…
- AMERICAN INDIANS ARE 2.5 – 3.5 TIMES MORE LIKELY TO EXPERIENCE
  - SEXUAL ASSAULT CRIMES COMPARED TO ALL OTHER RACES
- 1 IN 3 INDIAN WOMEN REPORTS HAVING BEEN RAPED DURING HER
  - LIFETIME

► US Department of Justice 2000, American Indians and Crime, BJS: 1999

LONG TERM CONSEQUENCES

- Physical injury
  - Strangulation, fractures, lacerations
- Mental health consequences
  - depression, anxiety, low self-esteem, suicide, intimacy issues
- Reproductive Health
  - Unintended pregnancy
  - Structural Injury
  - Sexually Transmitted Infections (STI)/HIV
- These consequences can lead to hospitalization, disability, or death

► *The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report*

HIV NATIONAL STATISTICS

- 1.1 MILLION PEOPLE ARE LIVING WITH HIV
- AGE – 13 AND OVER
- 1 IN 6 IS UNAWARE OF THEIR INFECTION (15.8%)
- 50,000 NEW CASES DIAGNOSED EVERY YEAR
- 15,529 PEOPLE WITH AIDS DIED IN 2010*
- MSM, 4% of population, accounts for 78% of new infections

*Death from all causes and may not be specific to AIDS diagnosis, CDC

HIV in INDIAN COUNTRY

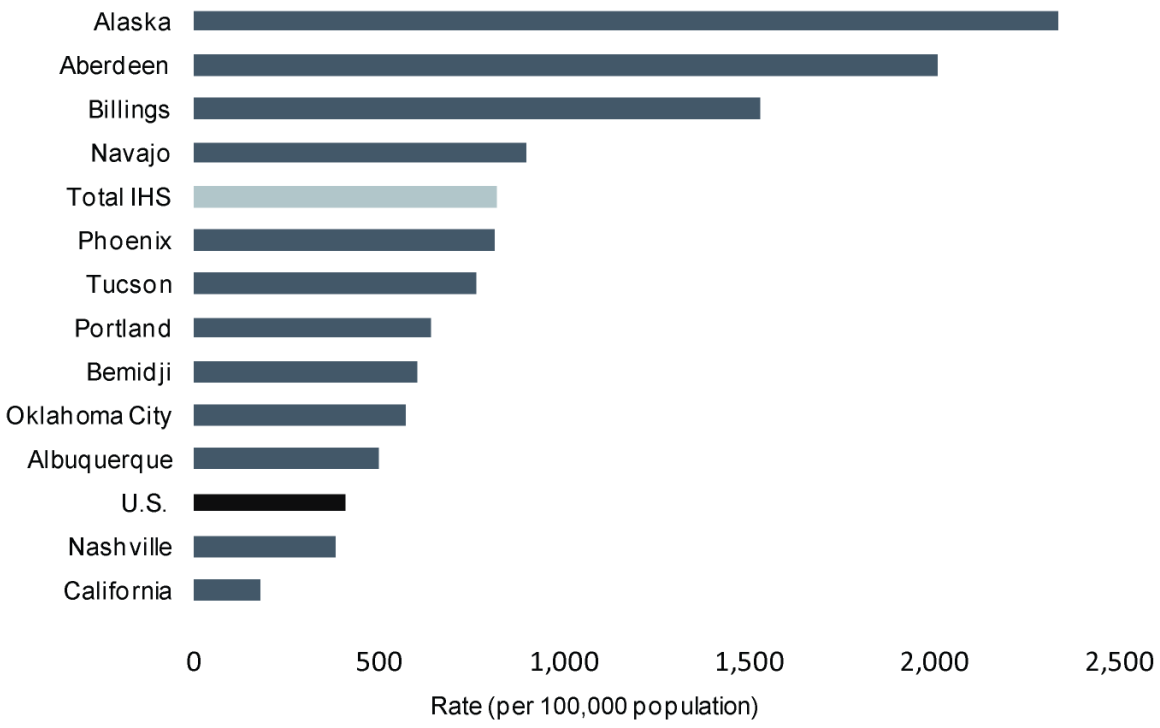
- 1.7% of the US population but ranks higher than whites in AIDS diagnosis
- Among the shortest life expectancy at Diagnosis (DX) –
  - often receiving AIDS DX at same time
- Rated 9th leading cause of death in Natives age 25-34
- 21% do not know status vs. 16% in general US population
- Native Women accounted for 24% of HIV/AIDS diagnoses
  - Heterosexual contact 63%
  - Injection Drug use (IDU) 37% - highest rate compared to all races/ethnicities

CDC 2014

RISK FACTORS

- SEXUAL
  - High rates of STI
  - Second highest rates of Gonorrhea/Chlamydia (GC/CT) are in
    - Native Americans
  - Rising Syphilis rates
- SUBSTANCE ABUSE
  - Increases high risk taking behavior
  - Native Americans among the highest reported rates (12.3%)

IHS 2009


Alaska
Aberdeen
Billings
Navajo
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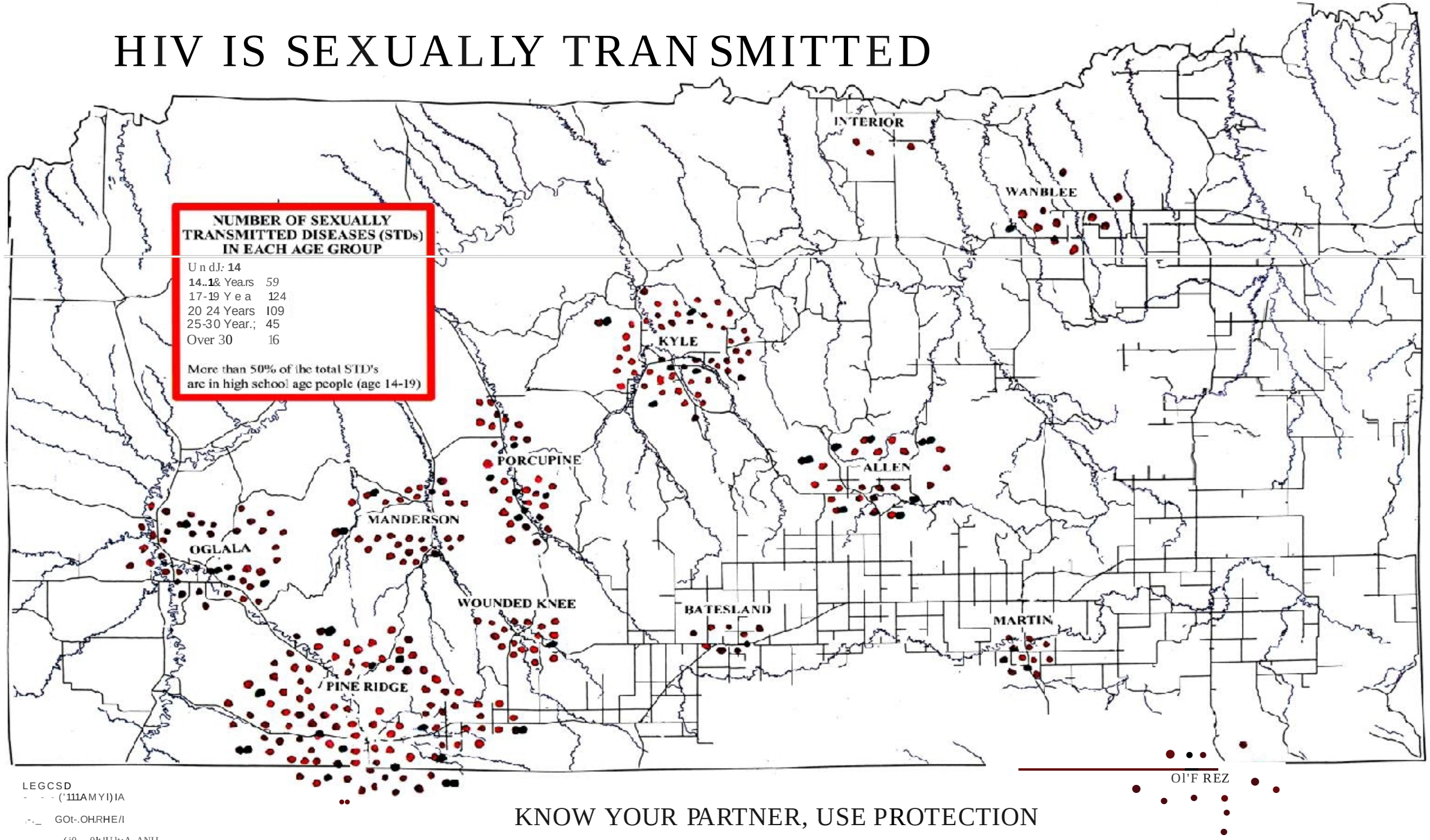
Phoenix
Tucson
Portland
Bemidji
Oklahoma City
Albuquerque
U.S.
Nashville
California
0
500
1,000
1,500
2,000
2,500
Rate (per 100,000 population)

HIV IS SEXUALLY TRANSMITTED



LEGCSD

KNOW YOUR PARTNER, USE PROTECTION

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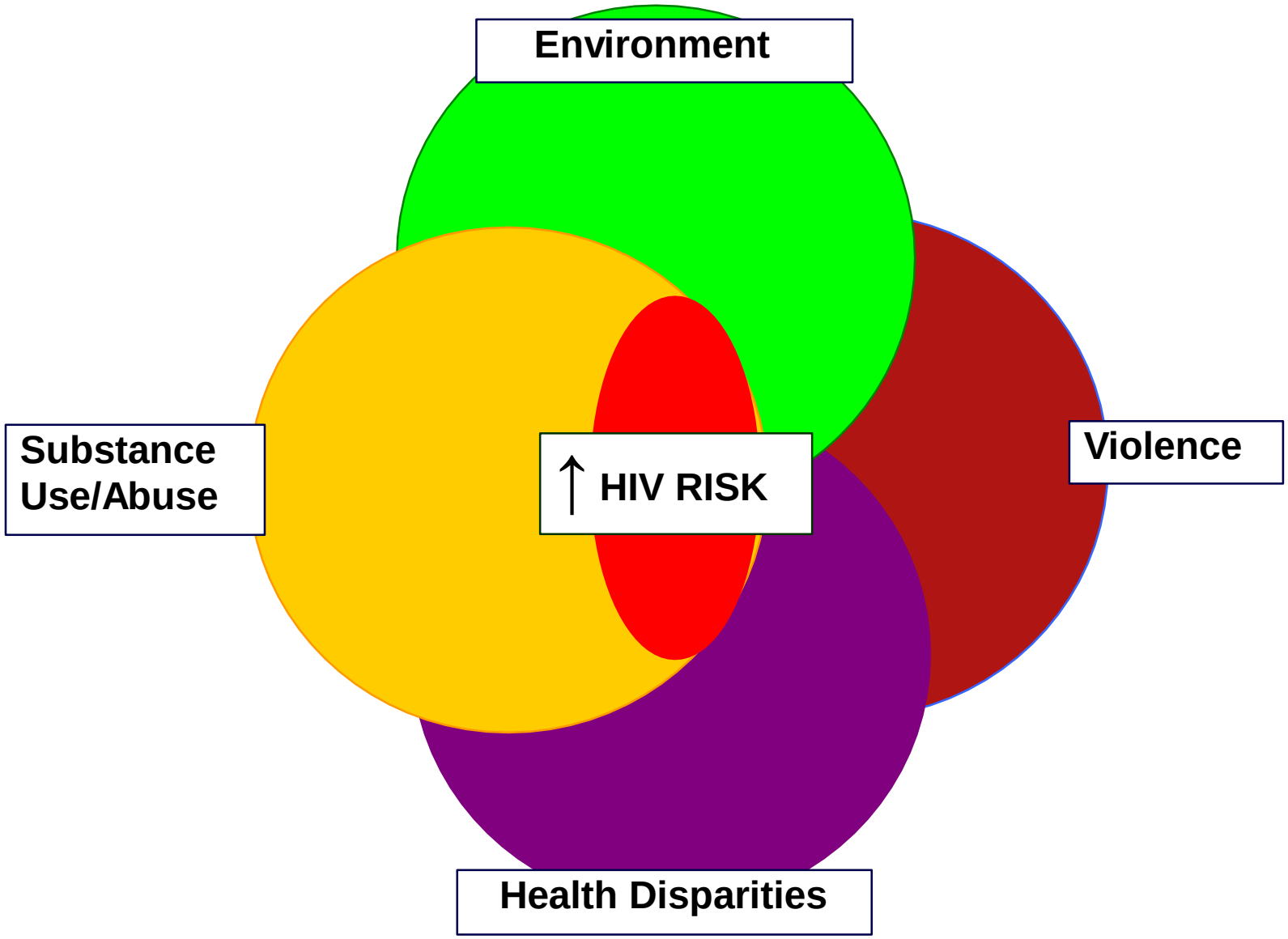
- SOCIOECONOMIC
  - Poverty – 24.4% Native
  - Twice the national average of 12.4%
  - Lack of Housing
    - Overcrowding
    - Homelessness
- HEALTH DISPARITIES
  - Higher rates of diabetes, pneumonia, infant mortality, auto
    - accidents
  - Poor Nutrition/food deserts

- VIOLENCE
  - Natives experience a per capita rate of violence at least twice that of the U.S. population
  - People may stay in violent homes as they have no where else to go, keeping the violence hidden under their roofs
  - Intimate Partner Violence (IPV), Sexual assault and abuse
    - Mucosal integrity with STI/sexual violence

US Commission on civil Rights 2004, U.S. Dept. of Justice 2004


Environment
Substance Use/Abuse
↑ HIV RISK
Violence
Health Disparities

LINK BETWEEN SEXUAL VIOLENCE AND HIV

- Over a decade of research worldwide shows undeniable link
- Relationship between Sexual Violence and HIV is complex
  - Driver of epidemic
  - Consequence of being HIV positive
- Rape is one cause of direct infection
- Primary burden of HIV risk
  - Gender inequality
  - Chronically abusive relationships
  - Women are repeatedly exposed to same perpetrator
  - Exposure to violence in childhood, adolescents, and as adults

Addressing violence against women and HIV/AIDS – WHO 2010

IPV AND HIV RISK

- Unable to negotiate safer sex practices
- Intentionally infect their partner
- Engage in sexual activity outside relationship
- Domestic Violence (DV) increases health problems, weakening immune
  - system, increasing risk of HIV infection when exposed
- Abusers can interfere with receiving medical care
- Threaten to reveal HIV status to family, friends, work
- Abusers control economic resources limiting access to care
- The threat of losing her home

BARRIERS TO SEEKING HEALTH CARE

- SEXUAL VIOLENCE

- Fear of mandatory reporting and losing control/privacy to government and Tribal agencies
- Lack of organized response (SART/SANE)
- Stigma
  - Self blame
  - Substance abuse
  - DV
- Loss of privacy
  - Small communities

HIV

- Fear of mandatory reporting to State
  - Health Department
- Lack of HIV specific care
- Stigma
  - Shame
  - Substance abuse
  - DV
- Loss of privacy
  - Small Communities

LGBT fears following sexual violence

- Not being taken seriously
- Negative experiences are minimized including sexual assault and rape
- Experiences are sensationalized
- Having to provide greater detail to the rape experience than opposite sex assault
- Being blamed for the assault
- Treated in a homophobic manner by police, hospital, rape center
- Mistakenly being perceived as the perpetrator
- Being “outed”

STIGMA

- Apart from the rest of society, bringing with it feelings of shame
  - and isolation
- people view the person as the problem rather than viewing the condition as the problem
- Prejudice, avoidance, rejection and discrimination directed at people believed to have an illness, disorder or other trait perceived to be undesirable.
- causes needless suffering, potentially causing a person to deny symptoms, delay treatment and refrain from daily activities

- exclude people from access to housing, employment, insurance, and appropriate medical care
- stigma can interfere with prevention efforts, and examining and combating stigma is a public health priority

CDC. Attitudes Toward Mental Illness—35 States, District of Columbia, and Puerto Rico, 2007. *MMWR* 2010;59(20);619–625

DOES STIGMA EXIST IN YOUR SETTING/PRACTICE?

- ARE YOU ASKING ABOUT SEXUAL ORIENTATION?
- UNCERTAIN OF HOW TO TALK ABOUT STI/HIV?
- UNSURE HOW TO ASK ABOUT SEXUAL VIOLENCE?
- COMFORTABLE ADDRESSING SAFE SEX WITH YOUR PATIENTS?
- EXPAND PRACTICE TO RAPID TEST FOR HIV?

ASSESSING FOR SEXUAL VIOLENCE and HIV RISK

- Understand your patient's individual health care needs
- Strengthens the therapeutic alliance through open discussion
  - Sexual Health / Reproductive Health Issues
  - History of Sexual Abuse
  - Opportunity to educate /counsel on relevant sexual activity risks for STI/HIV,
    - Viral Hepatitis
  - Increases screening opportunities
  - Connects patients to treatment and care which also impacts the health of partners and community
  - Guides direction of care including vaccinations, medications, referrals

WHY DON'T PATIENTS BRING IT UP?

- Lack of opportunity to bring subject up
- Sense of embarrassment and shame
- Societal taboo for open discussion of sexuality
- Unsure of discussion outcome
- Uncertain which specialty discusses sexual health issues
- Perceives provider as reluctant, disinterested, or unskilled in sexual
  - health

► Although et al, 2012, Journal of Sexual Medicine

SURVEY

- 500 men and women over age 25
- 85% expressed interest in talking to their providers about sexual issues
- 71% thought their provider would dismiss their concerns

Marwick, JAMA 1999

RESULT…

- Sexual history and risk is often not assessed
- Assumptions are often made
- More likely to be taken if Signs and Symptoms of STI
- Providers feel…
  - Discomfort with personal sexual questions
  - Inadequate Training
  - Unrealistic fear of offending patient
  - Time constraints

Implement Change into your Setting

- Medical Staff: Develop a policy for inclusion of a sexual history for
  - all patients, inclusive of LGBT, and provide training
- Administration: Foster a culture of acceptance and respect for all
  - patients; arrange for staff training across disciplines/roles
- Reception: Promote a welcoming atmosphere and confidential environment with phone calls, scheduling, and appointments

- Information Technology/Health Information: Develop Sexual History Templates for Electronic Health Record with forms that allow for sexual orientation and gender identity
- Behavioral Health: Program to include LGBT cultural competency
- Community Outreach: Create Public Service Announcements that include all community members with PSAs to education on sexual violence, STI/HIV, with contact numbers

WHITE HOUSE RECOMMENDATIONS

- Increase screening for intimate partner violence and HIV among women
- Improve outcomes for HIV+ women by addressing history of
  - violence and trauma
- Address factors that contribute to increased risk of violence among
  - women living with HIV

- The White House Office of National AIDS Policy 2013 released recommendations to address HIV and Violence against Women

CONTACT INFO

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FOUR DIRECTIONS CLINIC

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HIV Prophylaxis Following Sexual Assault
non Occupational Post Exposure Prophylaxis

- Recommended combination:
  - Tenofovir 300 mg + Emtricitabine 200 mg (Truvada) daily
  - + Raltegravir 400 mg BID
  - Alternative regimens
- Well tolerated
- Proven treatment success in established HIV infection
- Ease of use
- Starter pack supply of 3-5 days

PEP considerations

- Baseline testing (rapid test)
- Assess risk (not for low risk exposure)
- Do not deny on basis of repeat
- Timing
  - As soon as possible (within 2 hours)
  - 36 hours
  - Individual assessment (receptive anal intercourse with known HIV+)
  - National Clinician's Consultation Center PEPline 1-888-448-4911

IHS RESOURCES

- HIV program
- Behavioral Health
- Domestic Violence Prevention Initiative
- ECHO program for HIV telemedicine
- Chief Clinical Consultant for Infectious Disease
- Native Stand teen curriculum

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