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## Interventions to Address HIV and Intimate Partner Violence in Sub-Saharan Africa: A Review of the Literature

**Jocelyn C. Anderson, MSN, RN [Doctoral Student],**

Johns Hopkins University School of Nursing, Baltimore, MD, USA

**Jacquelyn C. Campbell, PhD, RN, FAAN [Professor and Anna D. Wolf Chair], and**

Johns Hopkins University School of Nursing, Baltimore, MD, USA

**Jason E. Farley, PhD, MPH, CRNP [Assistant Professor]**

Johns Hopkins University School of Nursing, Baltimore, MD, USA

### Abstract

HIV and intimate partner violence (IPV) are commonly co-occurring epidemics affecting the health of women globally and especially in sub-Saharan Africa. There is a need for interventions that address both HIV and IPV in health care settings. Our review examined recent literature for intervention studies that explored both HIV and IPV. Of the 9 interventions identified, only 2 were set in health care settings; the remainder were community based. Large multifaceted community-based interventions showed promise in the areas of addressing social norms in order to empower women. Educational interventions have shown short-term improvements in HIV-related knowledge and behavioral intention. Further research is needed to examine brief screening, intervention, and referral for HIV and IPV services within health care settings. Health care-specific interventions such as use of pre-exposure and post-exposure prophylaxis to prevent HIV transmission must also be studied in the context of IPV.

### Keywords

gender-based violence; HIV; intervention; intimate partner violence; sub-Saharan Africa

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Thirty-three million people are infected with HIV worldwide, with more than 2 million new infections each year (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2010). Sub-Saharan Africa accounts for greater than 22 million persons living with HIV (PLWH) in the world today. In this region, young women ages 15–24 are up to eight times more likely to be infected with HIV than their male counterparts (UNAIDS, 2010). Beyond biological or gender-based differences, gender plays an increasingly recognized role in the continued spread of the epidemic.

Research on the relationship between HIV and gender-based violence has been building over the past decade. Studies have shown a relationship between a history of sexual violence and HIV serostatus in the United States and sub-Saharan Africa (Maman, Campbell, Sweat,

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& Gielen, 2000). A more recent review identified that intimate partner violence (IPV) rates were higher in women living with HIV, and women who experienced IPV were more likely to report HIV and other sexually transmitted infections (STIs) than their counterparts who had not experienced relationship violence (Campbell et al., 2008). A similar review of U.S. research studies concluded that substance abuse is an additional risk factor in addressing IPV and HIV (Gielen et al., 2007), and the authors recommended focusing research on interventions to address women infected with HIV at risk for IPV and women experiencing IPV who may be at risk for acquiring HIV. Maman and colleagues (2000) also proposed three mechanisms through which IPV could contribute to increased HIV risk: (a) directly through transmission via forced intercourse with an infected partner; (b) indirectly through limiting women's abilities to negotiate safe sex practices, including condom use; and (c) indirectly through increased sexual risk-taking behaviors. Since that time, several important research studies have supported all three pathways, including the World Health Organization's (WHO) *Multi-Country Study on Women's Health and Domestic Violence* (Campbell et al., 2008; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Gielen et al., 2007; Jewkes et al., 2006; Maman et al., 2000).

The intersection of HIV and IPV, including potential causal pathways, in sub-Saharan Africa was examined prospectively and showed that women who experienced more than one episode of IPV over the course of a 2-year period were more likely to seroconvert than women who experienced zero or one episode of IPV during the same time period (Jewkes, Dunkle, Nduna, & Shai, 2010). These authors found that women with low self-reported relationship power were at greater risk for acquiring HIV and suggested that strengthening gender equality and preventing IPV has the opportunity to prevent one of every seven new HIV infections.

Nurses are already involved in addressing the HIV epidemic in sub-Saharan Africa. Nurse-led initiation and management of antiretroviral therapy (ART) in primary care settings is being evaluated as a way to provide more patients with access to HIV care (Fairall et al., 2008; Miles, Clutterbuck, Seatio, Sebego, & Riley, 2007). The relationships between gender equality, violence, and HIV have prompted the inclusion of violence against women and sexual violence prevention and response efforts into the South African National AIDS Council Strategic Plan (2011).

In addition to the work being done to address these issues separately, interventions are now being implemented to combat the dual epidemics of HIV infection and IPV. Because nurses make up a large portion of the health care workforce in sub-Saharan Africa and are becoming increasingly responsible for the operations of highly-used antenatal and antiretroviral clinics (Fairall et al., 2008; Institute of Medicine [IOM], 2011b; Munjanja, Kibuka, & Dovlo, 2005), nurses have the unique opportunity to assess for and intervene in the intersection of IPV and HIV. The aim of this paper is to critically examine interventions that have been studied in sub-Saharan Africa to address both HIV and IPV with the purpose of identifying interventions that might be implemented by nurses in Africa and other settings.

## Review Methods

Articles published in English from 2001 through January 2012 were systematically identified using an electronic search of PubMed, Embase, and CINAHL using the following keywords and subject headings: HIV, HIV infection, violence, domestic violence, intimate partner violence, battered women, Africa, prevention, and intervention. The initial search yielded more than 350 unique titles. Elimination of titles that were clearly not relevant to the subject of review and studies conducted outside of sub-Saharan Africa left approximately

100 abstracts for examination. Articles were included for review if they specifically addressed an implemented intervention that aimed to address both HIV and IPV. Hand search of the reference lists for chosen articles was also completed and resulted in finding two articles that described pilot or early testing of included interventions. The final review consisted of 17 articles that discussed implementation and resultant outcomes of 9 distinct behavioral intervention programs (note: several of the interventions had more than one published article evaluating different outcomes). Countries of origin for the articles were South Africa ( $n = 14$ ), Tanzania ( $n = 1$ ), and Nigeria ( $n = 2$ ). The articles that were reviewed were further described as interventions based in non-health care and health care settings.

## Findings

### Interventions in Non-Health Care Settings

To date, two large randomized control trials (RCTs) have been conducted in sub-Saharan Africa, specifically in South Africa, to evaluate multifaceted intervention strategies addressing prevention of HIV infection and IPV. While neither intervention study was able to show statistically significant decreases in measured HIV incidence rates, both have shown promise in other HIV and IPV related outcomes. The Intervention with Microfinance for AIDS and Gender Equality (IMAGE) study evaluated an HIV and gender equality educational intervention in addition to a microfinance program for adult women ages 18–96 ( $n = 430$ ) (Jan et al., 2010; Jan, Pronyk, & Kim, 2008; Kim et al., 2009; Kim et al., 2007; Pronyk et al., 2006; Pronyk et al., 2008). The Stepping Stones intervention consisted of approximately 50 hours of participatory education provided over a 6- to 8-week period and included content regarding sexual health and risk behaviors, contraception, HIV, communication skills, and gender-based violence presented to both men and women (Jewkes et al., 2008). Initially developed for Uganda, it has been adapted for use in more than 40 countries and 13 languages (Jewkes, Wood, & Duvvury, 2010). It was evaluated in a large ( $n = 2,776$ ) RCT of South African adolescents and young adults ages 15–26 (Jewkes et al., 2008).

The variety of outcomes and measurement strategies used in these two intervention studies created challenges in evaluating effectiveness. The Stepping Stones study was able to measure Type 2 herpes simplex virus (HSV-2) and HIV through laboratory testing, while IMAGE was not (Jewkes et al., 2008; Kim et al., 2007). Most promising from Stepping Stones was a 33% decrease in incidence of HSV-2 in the intervention group when compared to the control group (Jewkes et al., 2008). Intermediary measures found that these interventions prompted some improvement in HIV testing rates, HIV-related communication, and HIV-related sexual risk behaviors including condom use (Jewkes et al., 2008; Kim et al., 2007). Both interventions showed promise in decreasing IPV. The IMAGE study reported that IPV rates were 49% lower ( $RR: 0.51$ , 95%  $CI: 0.28–0.93$ ) in the group that received the gender-based education component in addition to the microfinance component. Fewer men participating in Stepping Stones reported IPV perpetration at 24 months than those in the control group (6% vs. 10%,  $p = 0.054$ ).

Public health and education have been evaluated in smaller scale studies across sub-Saharan Africa. Five primarily educational interventions were identified in the literature as having a specific focus on both HIV and IPV (Fawole, Ajuwon, & Osungbade, 2004; Fawole, Ajuwon, Osungbade, & Faweya, 2003, Jansen van Rensburg, 2007; Kalichman et al., 2008; Kalichman et al., 2009; Sikkema et al., 2010; Wechsberg, Luseno, Lam, Parry, & Morojele, 2006). Settings and populations varied from educational interventions designed specifically for small groups of men or women to a much larger community-based campaign with media and education efforts. Two programs offered some direct services (e.g., microfinance program, crisis hotlines) in addition to the education component (Fawole et al., 2004; Jansen

van Rensburg, 2007). In a household survey format, the media program enrolled 304 community dwelling women to evaluate the impact of the LifeLine media campaign and services; however, no baseline data were collected prior to the intervention period (Jansen van Rensburg, 2007). Of women who had participated in LifeLine activities or services, 100% reported that those services had provided them with educational content, and 98% indicated that they led to some behavioral change. The most common behavioral changes noted were “changes in self,” which included avoiding high-risk areas, not walking alone, and stopping drinking (85%), and increased condom use (61%).

A stepwise series of interventions to address HIV and gender-based violence against young high-risk women in Nigeria began with reproductive and HIV education, added behavioral risk reduction programs utilizing peer educators, and escalated to linked referrals to STI and family planning services along with a microfinance program (Fawole et al., 2004). As the interventions escalated, target populations extended including multiple groups of at-risk women as well as secondary targets that included police officers and older women and men who received a single education session addressing HIV and gender-based violence topics (Fawole et al., 2003). The 1-year evaluation showed an increase in reported gender-based violence knowledge and a decrease in reported rape attempts from 26% to 2% and completed stranger rape from 6% to less than 1%.

Trials of educational interventions ranging from 1 to 15 hours of program content have been completed in a variety of populations including female sex workers, women accessing IPV services, and community dwelling men. Sample sizes ranged from 97 to 475 (Kalichman et al., 2008; Kalichman et al., 2009; Sikkema et al., 2010; Wechsberg et al., 2006). Most commonly, temporary improvements in reported behaviors or behavioral intentions related to high-risk and safer sex practices were noted. When long-term follow up was possible, it tended to minimize the improvements in these pre-post-test or non-random comparison designs. None of these studies used laboratory measures of HIV status, some citing associated stigma and cost of HIV testing and treatment as barriers. Instead, they focused on associated risk behaviors, knowledge, and attitudes. South African men who participated in an education program reported less IPV perpetration and were more likely to have been tested for HIV at 6-month follow-up (Kalichman, et al., 2008; Kalichman, et al., 2009). At 1-month post-intervention female sex workers used condoms more frequently and reported fewer STI symptoms (Wechsberg et al., 2006). While self-report of symptoms is an imprecise measure of actual STI rates, the decrease in STI symptoms is still a promising finding because of the relationship between HIV, inflammation, and other STIs (Campbell et al., 2008; Hladik & Hope, 2009). Sikkema and colleagues (2010) compared a 6-week and 1-day HIV-prevention education program for an at-risk population of women currently living in or regularly visiting domestic violence clinics or shelters. Increased knowledge post-intervention was demonstrated with both interventions; however, larger differences were identified in the 6-week intervention group. Both groups also indicated lower numbers of sexual partners and fewer incidents of unprotected intercourse at the 2-month follow-up. Long-term behavior changes were not evaluated.

### **Intervention in Health Care Settings**

Only one study was identified that directly addressed both HIV and IPV in health care settings (Christofides & Jewkes, 2010). This intervention added IPV screening to standard care within the setting of an HIV counseling and testing (HCT) center. In post-intervention interviews, the researchers found that women were receptive to the idea of jointly addressing HIV status and risk in the area of IPV, and they reported that the intervention was beneficial. The study was limited by issues with both short- and long-term completion of the intervention. Not all HCT counselors were willing to complete the IPV screening and, at a 1-year follow up, there was no evidence of continued screening by HCT staff.

Another strategy tested to indirectly address IPV in HCT centers is the adoption of couples testing in place of the more common individual testing procedures. A qualitative examination of HIV counselors, men, and women in Tanzania identified resentment, abandonment, and violence as potential consequences of couples testing (Mlay, Lugina, & Becker, 2008). While couples' counseling offers an opportunity for tailored intervention in prevention strategies for the couple, serodiscordance was identified by a sample of Ugandan women as placing them at risk for violence (Emusu et al., 2009). A study completed in the setting of Tanzanian antenatal clinics showed that women randomized to receive couples testing were less likely to complete testing and receive their HIV test results (Becker, Mlay, Schwandt, & Lyamuya, 2010). The discrepancy between groups led the researchers to stop randomization in the couples group. From initial data, the researchers did find that women living with HIV who were willing to complete couples testing were more likely to report use of measures to prevent transmission to partners and more likely to receive medications to reduce the likelihood of perinatal transmission of HIV infection than the women who were randomized to the individual counseling and testing group.

## Discussion

Nurses provide primary and specialty care services to persons living with and at risk for HIV infection and have the opportunity to address IPV as a risk reduction strategy. Global studies have demonstrated that women who have experienced IPV favor routine screening by health care providers (Christofides & Jewkes, 2010; Joyner & Mash, 2011; Koziol-McLain, Giddings, Rameka, & Fyfe, 2008). Routine screening has been recommended by various nursing and medical specialty organizations along with the Institute of Medicine (American Medical Association, 2007; American Nurses Association, 2000; IOM, 2011a). However, efforts to establish culturally acceptable screening programs for IPV in the already overburdened health care systems in sub-Saharan Africa have been challenging (Christofides & Jewkes, 2010). Screening for IPV in health care settings has achieved a level of acceptance, at least in the United States. However, despite the evidence for concurrent risk, screening for HIV in IPV clinics and shelters has not yet been widely adopted (Sikkema et al., 2010). Further examination of HIV prevention strategies that also incorporate IPV assessment and prevention must be addressed in research and in practice. IPV adds further complexity to pre-exposure and post-exposure prophylaxis, risk-taking practices, and mental health and psychosocial well-being.

While no decrease in HIV rates have been shown, multifaceted community-based interventions such as IMAGE and Stepping Stones have shown promise in improving women's health and empowerment in sub-Saharan Africa. The results of these interventions as community-based approaches to addressing the dual epidemic of HIV and IPV in sub-Saharan Africa are promising but require replication. Moreover, these interventions neglect to provide the skill sets and practice concerns of nurses and other health care providers, many of whom have regular opportunities in their clinics to provide care for women who are both HIV-infected and who experience IPV. There is also a virtually unexplored area of utilization of these community and public health interventions in conjunction with other nurse-led health care interventions to further improve patient outcomes.

## Implications for Nursing

### Practice

Interventions to prevent IPV may have a dual role in HIV prevention. Unfortunately, the role of nurses and other health care practitioners in combating HIV and IPV was grossly absent from the current body of literature. There are a variety of ways in which the interventions presented in this review could be adapted to include the expertise of nurses and



other health care practitioners. The Stepping Stones, IMAGE, and Nigerian street worker interventions have provided evidence that community-based public health interventions can begin to impact health behaviors and outcomes. Incorporating nurses and other health care practitioners into such an intervention, which already makes use of lay health workers, may provide an opportunity to incorporate treatment and referral practices into educational and primary prevention programs.

Interventions in health care settings, such as couples HCT, need to be restructured to address the safety of women who may be placed at increased risk of violence as a result of their HIV status. Nurses and other health care practitioners practicing in HCT settings must be aware of this risk to women and the necessary precautions that must be taken to ensure the safety and confidentiality of women seeking HIV testing and HIV care (WHO, 2006). Post-test counseling and HIV treatment needs of women experiencing violence should also focus on partner disclosure, negotiating protective measures such as condom use, and promoting strong social support systems in the context of IPV (WHO, 2006). Where non-nursing staff provide HCT, nurses can become a part of the education, case management, and referral systems to assure that IPV concerns are addressed. The education programs presented here need to be assessed longitudinally in order to establish if long-term behavior change occurs. Collaborations between nurses, other health care practitioners, and lay health workers in such programs may allow for reinforcement of positive behaviors and long-term follow up via clinic visits of established patients.

While many of the community-based interventions have shown promising results, none have been thoroughly evaluated or shown to be effective in health care settings. Previous work on IPV screening has suggested that IPV screening for all women is a safe and acceptable practice, although comprehensive intervention screening alone may not improve outcomes (MacMillan et al., 2009; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011). Improving IPV screening and providing a brief clinical intervention and appropriate referrals for all women in health care settings continues to be an area in which further work is needed.

## Research

Continued evaluation of the long-term outcomes and sustainability of interventions such as Stepping Stones and IMAGE, ideally incorporating elements of the health care system to better identify, treat, and prevent the transmission of HIV is a key step in identifying options for best practice and further research. Nurses have unique opportunities and challenges in incorporating HIV and IPV prevention and treatment strategies into practice. Inclusion of community members of all ages, including young children, in gender equality programs that promote healthy relationships and primary prevention is another area in which research is needed. Nurses are already practicing in HIV-specific care settings (e.g., HCT centers, anti-retroviral centers) in which brief IPV screening, counseling, and referral interventions could be incorporated. Researchers and clinicians must attend to the details of implementation so that practitioners involved in screening for IPV are also aware of appropriate safety strategies and local referral options.

While HIV specific care sites provide access to individuals who may be at great risk, primary care and emergency care settings should not be ignored as sites in which patients experiencing violence in their relationships can be identified. Pre-exposure prophylaxis (PrEP) is another emerging therapy that has been tested in populations at high risk for HIV (i.e., men who have sex with men and sero-discordant heterosexual couples [Eisingerich et al., 2012; Kelesidis & Landovitz, 2011]). If women experiencing IPV can be identified as high risk for HIV infection, possibilities exist for translating PrEP into this clinical population. Further study is clearly needed to determine the impact of PrEP in this vulnerable, high-risk group.

The growing role of nurses in providing care to patients following IPV-related sexual violence provides yet another venue for nurses to become involved in promoting HIV prevention. Creation and utilization of meaningful protocols for HIV post-exposure prophylaxis allows patients who have been sexually assaulted to minimize the risk of acquiring HIV infection. While this intervention has been established, it is not being universally implemented (Draughon & Sheridan, 2011).

Ideally, interventions should be tested in a manner that is able to translate efficacy in research settings into effectiveness in the demands of extraordinarily busy clinical settings. Use of cluster randomized trials in which clinical settings are randomized to include IPV and HIV screening and treatment options may help to highlight the strengths and barriers to wide-scale dissemination.

In the ongoing challenge to address the joint epidemics of IPV and HIV, various interventions are being trialed in public health, education, and economic arenas. With the risk of both HIV and IPV to an individual's health status, it is imperative that nurses are incorporated in future interventions. Multidisciplinary public health approaches such as IMAGE and Stepping Stones may be improved and implemented more widely by utilizing the skill sets of nurses and other clinic and hospital-based practitioners. Increasing the acceptance of screening for IPV and establishing safe screening and intervention programs in settings in which continuous HIV care is being delivered to women may be avenues for long-term nursing intervention.

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### Clinical Considerations

- HIV and IPV are both major health concerns for women globally, particularly in sub-Saharan Africa.
- Nurses and other health care practitioners providing HIV care must be aware of the effects IPV may have on treatment.
- Community-based interventions with gender equality components, economic empowerment, and consciousness raising show promise in decreasing IPV and sexual violence that may affect HIV transmission rates.
- Screening, prevention, and intervention programs for IPV and HIV in health care settings must be further implemented and evaluated to determine best practices.