



Published in final edited form as:

J Acquir Immune Defic Syndr. 2013 September 1; 64(1): 1–2. doi:10.1097/QAI.0b013e3182a29f1b.

Improving Health Outcomes for IPV-Exposed Women Living with HIV

Gina M. Wingood, ScD^{1,2,3}, Ralph J. DiClemente, PhD^{1,2,3}, and Puja Seth, PhD^{1,2,3}

¹Emory University Rollins School of Public Health, Department of Behavioral and Health Education

²Center for AIDS Research, Emory University

³Women's Interagency HIV Study, Emory University

Engagement, retention and continuity of care for women living with HIV may reduce HIV transmission, reinforce prevention messages, promote HAART adherence and enhance monitoring of sexually transmitted diseases (1). National estimates suggest that 42-59% of HIV-infected adults are not-in-care (2,3). Given the adverse consequences of poor engagement in HIV medical care, understanding patient characteristics associated with poor engagement is a clinical and public health priority.

HIV-infected individuals may be categorized along a continuum of engagement in care: those never in care, those with inconsistent care and those with consistent medical care (3-5). This commentary accompanies the manuscript by Siemieniuk, Krentz, Miller et al., The Clinical Implications of High Rates of Intimate Partner Violence Against HIV-Positive Women (6). In this study, 339 HIV positive women receiving outpatient care were screened for intimate partner violence (IPV). Findings from this study corroborate existing empirical data demonstrating that exposure to IPV may increase risk for HIV transmission, perhaps as a consequence of poor mental health, illicit substance use, riskier sexual practices or history of incarceration. However, this manuscript also extends the literature to examine associations between IPV and a diverse range of adverse behavioral, clinical and health outcomes among women living with HIV.

The authors observed a 40% prevalence of IPV among their sample of women living with HIV. Women reporting IPV had higher rates of smoking, illicit substance use, depression, anxiety disorders, incarceration histories, history of childhood abuse and diminished health-related quality of life. Moreover, IPV-exposed women were significantly more likely to be hospitalized compared to IPV-unexposed women (256 times/1000 patient-years versus 166/1000 patient years, respectively, $P < 0.001$). Additionally, the relative risk for HIV-unrelated hospitalizations and for HIV-related hospitalizations *after* outpatient HIV care was initiated was markedly increased for IPV-exposed women. Adverse clinical health outcomes also included decreased use of antiretroviral therapy and additional interruptions in care longer than one year (6).

Contact Information Gina M. Wingood, ScD, MPH Emory University Rollins School of Public Health 1518 Clifton Rd., 5th floor, Room 554 Atlanta, GA 30342 gwingoo@emory.edu Telephone: 404-727-0241.

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Limited research has been undertaken to understand why IPV-exposed women living with HIV have suboptimal engagement in care. Some data suggest that women may have conflicting priorities that interfere with seeking HIV medical care. These challenges may include illicit drug use, unstable housing, poor coping, anxiety or depressive disorders or limited access to health insurance. These factors, many of which were observed in the study by Siemieniuk, Krentz, Miller et al., may limit the ability of IPV-exposed HIV-infected women to effectively navigate the health care system. Further, research should explore methods, such as use of peers or paraprofessionals (5) to facilitate women's ability to effectively navigate the oft times labyrinthine health care system. Additional research has also shown that the limited accessibility of medical services is an important factor that may promote linkage and potentially engagement with care (5). Thus, colocating trauma services with medical services that HIV-positive women typically receive facilitates retention in care and improve their quality of life

A previous study evaluated a new linkage strategy to facilitate early entry into medical care for recently diagnosed HIV infected persons. The Antiretroviral Treatment Access Study-1 (ARTAS-1) was a randomized controlled trial that compared a brief strengths-based case management intervention with an enhanced standard of care. The ARTAS-1 trial found that 78% in the case-managed arm versus 60% in the enhanced standard-of-care arm were linked to medical care within 6 months. Using the results of this CDC-defined evidence-based intervention, strengths-based case management interventions could be conceptualized within a trauma-informed care perspective (7). This perspective may be one approach to enhance engagement in care, improve quality of life and reduce the myriad adverse outcomes observed in the lives of HIV positive women by Siemieniuk, Krentz, Miller et al (6).

The importance of trauma-informed care cannot be overestimated (8). Trauma-informed care is an approach to that recognizes the presence of trauma symptoms and acknowledges the role that trauma plays in people's lives. Trauma-informed care may be indicated precisely because the study observed that women who experienced IPV found it more difficult to remain engaged in HIV care. Women in violent relationships, who also are living with HIV, may fear that disclosure of their HIV status could lead to further physical, emotional, or psychological abuse from their male partner. Due to the lack of social support and other psychosocial factors, they also may be less likely to obtain critical medical services. It is important to note that IPV exacts a significant toll on women's health, not only through physical abuse, which results in observable significant physical injury, but more insidiously through the psychological and emotional effects that impair women's capacity to enact health-protective behaviors.

The outcomes observed by Siemieniuk, Krentz, Miller et al. (6), should be used to educate health care providers about the importance of screening HIV positive women for IPV, carefully facilitating their linkage into care, monitoring their retention in care, and providing ancillary social work and counseling services and, if need be, safe shelter and sustenance. Certainly, the diverse array of resources needed goes well beyond the standards of traditional HIV medical care; however, as the growing empirical evidence demonstrates lack of IPV screening and insufficient services often result in poor health outcomes. Indeed, the human cost, in terms of suffering, poor health behaviors and adverse health outcomes, is further magnified by substantial overall healthcare costs.

A greater understanding of how IPV impacts women's health and the HIV treatment cascade should be undertaken. There are several hypothesized mechanisms through which IPV may impact health-related outcomes and the HIV treatment cascade. These mechanisms include: fear of abuse leading to greater tolerance of partner's risk behavior resulting in impaired sexual decision-making, fear of disclosing HIV serostatus, low self-worth or self-esteem,

lack of control, adopting poor coping strategies, such as substance abuse, and psychological impairment, such as depression or anxiety (9, 10). A greater understanding of the pathways through which IPV exerts its adverse impact would be valuable in designing more effective psychosocial interventions.

While researchers have sought to understand how the treatment cascade may differ by social factors such as gender and race, limited attention has focused on IPV exposure. Within North America, further research is needed to understand how IPV impacts the HIV treatment cascade of ethnic minority women in the United States, women who are disproportionately impacted by HIV, and experience high rates of IPV and have low rates of linkage to care. Outside of North America, understanding the clinical implications of IPV exposure in sub-Saharan African, among women burdened by the dual epidemics of IPV and HIV, would also be a high priority. Given the importance of engagement in HIV care, there is a clear, cogent and compelling urgency to integrate IPV screening into clinical practice, routinely screen women for exposure to IPV and provide a continuum of relevant social, psychological and health services to mitigate the myriad adverse health consequences of IPV.

Acknowledgments

This project was funded by the Emory Center for AIDS Research (P30 AI050409), Award Number T32AI074492 from the National Institute of Allergy and Infectious Diseases and the Women's Interagency HIV Study (WIHS-V) (U01AI1103408).

REFERENCES

1. Montaner JSG, Montaner JS, Hogg R, Raboud J, Harrigan R, O'Shaughnessy M. Antiretroviral treatment in 1998. *Lancet*. 1998; 352:1919–1922. [PubMed: 9863802]
2. Henry, J.; Kaiser Family Foundation. HIV/AIDS Policy Fact Sheet: The Ryan White Policy Program Volume 1-2 [cited 2007 12/15/2007]. http://www.kff.org/hivaids/upload/7582_03.pdf
3. Giordano TP, et al. Retention in care: a challenge to survival with HIV infection. *Clin Infect Dis*. 2007; 44:1493–1499. [PubMed: 17479948]
4. Ikard K, Janney J, Hsu LC, Isenberg DJ, Scalco MB, Schwarcz S, et al. Estimation of unmet need for HIV primary medical care: a framework and three case studies. *AIDS Educ Prev*. 2005; 17:26–38. [PubMed: 16401180]
5. Gardner EM, McLees MP, Steiner JF, del Rio C, Burman WJ. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. *Clin Infect Dis*. 2011; 52(6):793–800. [PubMed: 21367734]
6. Siemieniuk RSC, Krentz HB, Miller P, Woodman K, Ko K, Gill J. The clinical implications of high rates of intimate partner violence against HIV-positive women. *JAIDS This special issue*. 2013
7. Gardner LI, Metsch LR, Anderson-Mahoney P, Loughlin AM, del Rio C, Strathdee S, et al. Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. *AIDS*. 2005; 19(4):423–431. [PubMed: 15750396]
8. Harris, M.; Fallot, R. *New Directions for Mental Health Services*. Vol. 89. Jossey Bass; 2001. Using trauma theory to design service systems.
9. Ellsberg M, Jansen HAFM, Heise L, Watts CH, Garcia-Moreno C, WHO Multicountry Study of Womens Health. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet*. 2008; 371:1165–1172. [PubMed: 18395577]
10. Edwards VJ, Black MC, Dhingra S, McKnight-Elly L, Perry GS. Physical and sexual intimate partner violence and reported serious psychological distress in the 2007 BRFSS. *International Journal of Public Health*. 2009; 54:S37–S42.