Capacity of AIDS Service Organizations in Connecticut to Respond to Intimate Partner Violence

Margaret L. Prust[a,*], **Lauren Mellor-Crummey**[b,**], **Tami Sullivan**[c], **Shawn Lang**[d], **Nathan B. Hansen**[c,***]

[a]School of Public Health, Yale University, New Haven, CT, United States;

[b]Yale College, Yale University, New Haven, CT, United States;

[c]Department of Psychiatry, Yale School of Medicine, 389 Whitney Ave, Yale University, New Haven, CT, United States;

[d]AIDS Connecticut, Hartford, CT, United States

Abstract

Although intimate partner violence (IPV) is prevalent among women living with HIV and negatively impacts their health, few studies have examined the ability of AIDS service organizations (ASOs) to address IPV. This study used a qualitative approach to identify facilitators of and barriers to addressing IPV in female clients of ASOs in the United States. In-depth interviews were conducted between March and August 2011 with 20 ASO staff members and 19 female clients who reported a current or past history of IPV. Interviews were audio recorded, transcribed, and analysed using the constant comparative method. These data identify barriers to addressing IPV at the organization, provider, and client levels and include suggestions from both clients and providers about improving access to care. Client and provider suggestions differed in some areas. While providers emphasized structural changes such as increased training on IPV provided by their organization, clients highlighted the importance of trusting personal relationships with staff to increase client disclosure of IPV experiences. Given the differing opinions of clients and staff, ASOs should consider involving women with histories of IPV in the process of programme and policy development. ASOs have the unique opportunity to provide comprehensive and holistic care by addressing IPV. The extent to which ASOs are able to recognize and address IPV and strategies for increasing this ability warrant greater attention from funders, ASO administrators, and researchers.

Keywords

intimate partner violence; HIV; women; AIDS service organizations; qualitative research

[*]Corresponding author: Margaret L. Prust (margaret.lippitt@aya.yale.edu, Phone: 706-577-0034; Present address: Clinton Health Access Initiative, 383 Dorchester Avenue, Boston, MA 02127).
[**]Present address: UT Health Science Center at Houston, Department of Internal Medicine, Division of Medical Genetics, 6431 Fannin Street MSB 6.100, Houston, TX 77030
[***]Present address: Department of Health Promotion and Behavior, College of Public Health, University of Georgia, 330 River Road, Athens, GA 30622

Background

The co-occurrence of HIV and physical, sexual, and psychological intimate partner violence (IPV) has emerged as a significant public health problem (Amaro 1995, Wingood & DiClemente 1997, El-Bassel et al. 2003, Gielen et al. 2007). One-third of adult women in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime, and 6% have had these experiences in the last year (Black et al. 2011). Among women living with HIV, rates of IPV are much higher, with as many as 27% having experienced IPV in the last year (Illangasekare et al. 2012). Women living with HIV may also experience IPV with greater frequency and severity compared to those without HIV (Gielen et al. 2007).

IPV negatively impacts the physical and mental health of women (McDonnell et al 2003, Burke et al. 2005, Coker 2007, Black et al. 2011); however, IPV may be particularly harmful for women living with HIV by decreasing their access and adherence to care and treatment, thereby facilitating disease progression. Previous research provides ample evidence that trauma or abuse is associated with a decreased CD4 count, increased HIV viral load, and greater risk for clinical decline and mortality (Leserman 2008). Additionally, women living with HIV who have a history of IPV have been shown to be at higher risk for experiencing depressive symptoms and missing gynaecologic appointments (Illangasekare et al. 2012).

Since case managers and other service staff at AIDS service organizations (ASOs) have frequent contact with their clients, they are in a unique position to address many health issues closely related to HIV among women. ASOs are community-based organizations that provide a range of services for people living with or at risk for HIV, such as education and outreach, HIV testing and counselling, subsidized housing and medical case management. Some ASOs provide direct services such as housing or addiction counselling, and others are focused on providing referrals and links to care or helping clients to navigate complicated social welfare systems. The majority of ASOs in the United States offer supportive services rather than fee-for-service or billable treatment, meaning that the majority of funding for ASOs comes through competing for government or private grants and contracts, and other fund-raising activity. While the AIDS care system recognizes and addresses issues that relate directly to HIV risk, such as risky sexual behaviour and substance use, it does not routinely address IPV despite its detrimental consequences for these women's health (Lennon et al. 2013). Failure of ASOs to address IPV represents a missed opportunity to support women in accessing crucial care and making empowered health decisions. However, little is known about the degree to which ASO staff members possess the necessary knowledge and skills to provide IPV services and other barriers to the provision of IPV-related services. Several studies have expressed the need for more research to inform interventions and programmes focused on the prevention or management of IPV among women living with HIV to promote better overall health outcomes (Gielen et al. 2007, Meyer et al. 2011).

Accordingly, this study assessed the extent to which ASOs in Connecticut address IPV among their clients and identified potential programmatic and policy development as well as training strategies to improve ASOs' detection and treatment of IPV. Specifically, we aimed to identify key challenges and barriers that ASOs face in providing IPV-related services from

both staff and client perspectives as well as document key facilitators and potential strategies identified by staff and clients to improve ASOs' ability to address IPV.

Methods

This study utilized in-depth qualitative interviews with purposeful samples of (a) ASO staff and (b) HIV-positive female clients of ASOs with a current or past history of IPV. Interviews captured their complex experiences and detailed insights. Since research in this area is lacking, qualitative methods were ideal for exploring key concepts and enabling previously unconsidered themes to emerge.

This study was conducted through a community-based research partnership between an NIH-funded HIV/AIDS academic research centre, the Yale University Center for Interdisciplinary Research on AIDS (CIRA), and AIDS Connecticut, a private, non-profit organization that acts as an umbrella organization to coordinate approximately 40 member organizations that provide HIV/AIDS-related services throughout Connecticut. The project emerged directly from the needs of the community-based partners and was funded by a competitive community-partnership award sponsored by CIRA. All research activities were planned and implemented collaboratively by both university and community partners. This research was reviewed and approved by the Yale University Human Subjects Committee.

Data collection

Interviews were conducted between March and August 2011 with information-rich, purposeful samples of ASO staff and female clients living with HIV with a current or past history of IPV. ASOs were selected to provide regional representation from across the state, including one ASO in each of the six major cities and four ASOs in more rural areas. ASO administrators were asked to assist in identifying staff with diverse backgrounds, perspectives, and roles within the ASOs that would be well-positioned to speak on issues related to IPV. To ensure diverse perspectives in the sample, no more than two staff participants were selected from a single agency.

For client interviews, we posted flyers in the selected ASOs announcing a study interviewing women living with HIV about their relationships. The flyers included a phone number that potential participants could call to be screened for eligibility. Women were eligible to participate if they (1) reported a current or past history of IPV, (2) were 18 years or older, and (3) spoke English. Interviews were conducted in-person by a female research assistant with training in clinical psychology and qualitative research methods. Written informed consent was obtained from each participant before conducting the interview. Interviews were conducted in a private room in the various ASOs where participants worked or were seen as clients. Participants received a $25 gift card as compensation for their participation.

The questions included in the interview guides were developed collaboratively with staff from AIDS Connecticut. Interviews with ASO staff included questions about training on IPV, experiences working with clients with IPV, awareness about IPV and related resources, and barriers and challenges to addressing IPV within their organization. Interviews with

female clients included questions about personal experiences with IPV and about seeking services related to IPV through ASOs, as well as barriers to obtaining support related to IPV. These domains were of *a priori* interest to the research team based on literature reviews and consultation with community partners involved in programme planning. While the key domains of the questions remained the same, the probes became more sophisticated over time. The interviews lasted approximately 45 to 60 minutes each.

Data analysis

Interviews were audio recorded and transcribed verbatim, then reviewed by the interviewer to ensure accuracy. Transcripts were coded by a multi-disciplinary, four-person research team, using the constant comparative method to systematically create a code structure based on interview questions and derived from study participant responses (Glaser & Strauss 1967, Miles & Huberman 1994). The analysis team members began by reading and independently coding the same transcripts, and then meeting to develop a coding structure. Team members then applied the coding structure in teams of two and compared transcripts to ensure consistency. Throughout this process, the coding structure was refined until a final, comprehensive coding structure was developed, and then the final codes were applied to all transcripts (Bradley 2007). Qualitative analysis software (ATLAS.ti 6.0) was used to facilitate data organization and retrieval (Richards 2002). The quotations included in this article were selected based on their clarity and ability to illustrate a given theme or pattern.

Findings

Characteristics of the Sample

In-depth interviews were conducted with 20 staff members and 19 clients. The staff members had been working in the social services field for an average of 15.4 years, with a minimum of 3 and a maximum of 30 years. Ten of the staff members primarily were involved in direct service provision, such as case management and outreach. The other ten staff members were mostly involved in administration or supervision, though many of the administratively-focused staff had backgrounds in direct service provision. All staff members worked in organizations that provide case management support, with some organizations having a stronger focus on one particular issue such as housing or addiction. All of the client-participants were female and HIV-positive. Six client-participants were experiencing IPV at the time of the interview and 13 previously had experienced IPV. All 19 clients reported experiencing verbal or emotional abuse, and 15 clients reported instances of physical abuse.

Barriers to addressing IPV in ASOs

Key barriers to addressing IPV at the organizational, provider, and client levels were identified by ASO staff and clients (Table 1). Organizational-level barriers are issues that affect all providers and clients that seek services from an organization. Provider-level barriers relate to the background, training, and behaviour of individual providers and have an impact on provider-client interactions. Client-level issues are particular to a client and her own personal circumstances, emotions, or experiences.

Organizational or structural barriers—ASO staff members pointed to a number of organizational issues that limited their effectiveness in responding to IPV, including a dearth of policies and protocols for addressing IPV and lack of coordination of care between the ASO and other organizations that provide related services. Both ASO staff and clients recognized that the structure of ASOs, the types of service encounters, limited funding, and the availability of IPV services were challenges to addressing IPV within ASOs.

Most staff reported that they were unaware of any agency policies, protocols, or processes about how and when to screen for IPV and the kind of support to provide once IPV was identified. Staff also reported that ASOs lack structured assessment tools to screen for IPV during the client intake or screening process.

> "If we do [screen for IPV] more formally, how does it fit? Where does it go? … Do we try to talk about it at admission? Do we do it more formally during every assessment? … It's like just sorting it out and adding it into already a very dense layer of protocols."
>
> – Staff Interview 103

Some staff believed that a key barrier to effectively coordinating HIV and IPV care was the fragmented provision of services, where agencies or departments provide one type of service or address one issue without the capacity to comprehensively address client needs. Also, weak relations and poor communication among agencies or departments were of great concern, as described by this ASO staff member: "Resources is not our problem… Our problem is bridging the resources. There's all these resources and they compete against each other instead of working together" (Staff Interview 112).

Even within a single organization or department, clients faced challenges in disclosing IPV due to the structure of service encounters. Specifically, clients referred to the public setting of services, types of services, and the short appointment times as obstructive to addressing IPV.

> "It's the same questions all the time… [My case manager] asks about my health… What do I need help with: transportation, medical, housing, whatever. It's the same questions all time. When we do our update, it only takes like all of sixty seconds."
>
> – Client Interview 208

Many participants indicated that these organizational challenges were linked to a single root cause: lack of funding for IPV services in general. A significant number of staff members and clients discussed concerns that the IPV services available are insufficient to meet the needs of the community regardless of HIV status. ASO staff felt that they had limited options for making referrals and supporting patients in seeking care. Clients also were frustrated with unsuccessful attempts to seek help.

> "They need to make more crisis centres available because I remember one of the times that I did call the crisis centre, they didn't have any beds available. So that's one of the times that I wasn't able to get away."
>
> – Client Interview 204

Within ASOs, funding also has a significant impact on the types of services provided. In recent years, stable or dwindling funding for HIV care has become a significant issue as ASOs provide services for a growing population of individuals with HIV who are living longer. Even when staff recognized that IPV-related services were needed, the agencies' priorities were directed by funding sources.

> "In order to make time to do things, there needs to be funding for the services. So you may want to have more groups specifically for domestic violence but, if your funding is geared for something else, that's going to be your priority."
>
> – Staff Interview 109

Provider-level barriers—While organizational barriers and challenges affect all staff and clients, study participants raised other issues related to the background and behaviour of individual providers. In particular, clients and providers both expressed that low levels of training and awareness related to IPV among providers, as well as poor relationships between clients and providers, can prevent productive conversations about IPV.

Many providers felt strongly that they and their colleagues had not received adequate training on the topic of IPV. Lack of training was presented not only as a provider-level barrier to addressing IPV, but also as an organizational issue since organizations either did not offer training or did not encourage staff to pursue training opportunities. However, training varied across organizations. Even though some providers had received training, staff turnover and the lack of continuing staff education on IPV left many providers ill-prepared.

> "In the field of social services there's just a huge turnover of people, I mean a lot of agencies turn over a third of their employees a year, so… you can't just do it [training] once, it's got to be consistent."
>
> – Staff Interview 102

Clients suggested that due to this lack of training, their ASO providers had never asked them questions about IPV or did not seem comfortable discussing the topic. Providers also identified low IPV awareness among some ASO staff as a key challenge: "I think when it [IPV] comes up sometimes it catches the case managers off guard" (Staff Interview 117).

Another barrier to addressing IPV is the lack of positive and supportive relationships between clients, their case managers and other providers. We are describing the relationships between clients and providers as a provider-level issue because the individual approach of a single provider to their client interactions has the potential to impact many clients. Because of the nature of these relationships, many clients reported that they did not feel comfortable sharing their experiences of IPV. One client felt the relationship with her provider was business-like rather than comfortable and supportive:

> "I didn't tell [my case manager]… She told me that she's not my friend; she said this is strictly business… That stopped me right there, because even though she was interviewing me, I interviewed her, too… She's a big part of my life, my personal life, my private life, you know what I mean. It's not that I'm looking for a relationship… but I'm looking to know that I could feel comfortable."

– Client Interview 208

While clients commonly raised this barrier to care, none of the provider participants discussed challenges related to the lack of a trusting relationship between clients and providers.

Several clients also expressed concern that providers might not respect their confidentiality. In some cases, clients felt that their confidentiality had already been violated by providers discussing their information with other staff members without permission of the client. Some clients reacted negatively to this breach of confidentiality and lost trust in their providers. However, other clients appreciated that staff shared background information with other providers in an effort to improve their care.

Client-level barriers—Finally, client level barriers to seeking and receiving IPV care included perceptions of stigma, feelings of fear and shame, lack of awareness about IPV and IPV resources, as well as other challenges related to individual client circumstances. The most common client level barriers mentioned were related to the community stigma surrounding IPV. While the prevalence of stigma is a broader societal issue, participants mentioned stigma in this context as an internalized sentiment that caused clients to feel uneasy disclosing their IPV experiences and providers to feel uncomfortable addressing the issue.

> "There's just something so demoralizing about being physically abused, sexually assaulted, that it is such an egregious wound that people protect it in that way, and I think that what supports that is the stigma… Many survivors say things like, 'Well who would believe me? Who would believe this?'"

– Staff Interview 106

Similarly, clients and staff also discussed the role that emotions such as fear, shame, and low self-esteem play in preventing women from disclosing a history of IPV or actively seeking services to address the issue. Several participants also emphasized the ways in which this challenge may be more acute for women living with HIV.

> "It's a different situation when someone's not positive. [HIV-positive women think] they have to stay with this person because of their status. They kind of feel obligated to stay in the situations because of their status; they think they won't be able to find anyone else."

– Staff Interview 108

In addition to these feelings of stigma, fear, and shame, other clients may experience more passive barriers, such as a lack of awareness about how IPV is defined and how to access services. In particular, clients and staff felt there was a general lack of awareness about the emotional and psychological dimensions of IPV among clients and in the broader community.

> "People forget about the mental and the emotional abuse… When someone yells at you, it's not okay… I think it's become society's norm that this behaviour is

acceptable, and for some women who have received that from their father to their boyfriends and their husbands, think that it's okay."

– Staff Interview 111

Some clients also mentioned lacking knowledge about how to access services or find support for IPV-related issues, indicating low awareness of IPV resources. This barrier also may be viewed as an organizational and provider level issue since ASOs should help women access the services they need.

Finally, participants reported a number of barriers related to individual clients and their unique circumstances. Clients frequently face a number of challenges related to physical or mental health, children, housing, and/or addiction. In the face of other pressing issues, clients and staff do not prioritize addressing IPV.

"If a client's biggest issue is housing and their housing isn't stabilized, how are they to focus on going to the doctor? How are they to focus on coming to see me if they are in the process of eviction or their rent is too expensive… If their housing isn't stabilized, there is nothing else that is going to be stabilized."

– Staff Interview 109

Several clients also mentioned concerns about the consequences for their partners, such as punishment or legal action, related to their disclosure of IPV to ASO staff. Others expressed fear of the personal consequences of disclosure. Specifically, some clients felt that if their partners discovered that they had discussed their history of IPV with providers, their partners might retaliate with more aggression, as described by this client: "I would never go, because I would be afraid that I would be hurt because I told the guy that I was going to [receive IPV services from] someone" (Client Interview 202). This is critical not only from the perspective of receiving IPV services, but also because a woman's abusive partner may also actively or passively interfere with her HIV care. For example, one client said, "He used to fight with me and make me not take my medicines" (Client Interview 217). Whether a partner interferes directly with a patient's HIV care or diminishes her self-worth to the point of limiting the patient's ability to engage in self-care, these partner relations can have a major impact on access to both IPV and HIV care.

Suggested facilitators for addressing IPV in ASOs

In addition to the barriers and challenges to addressing IPV, ASO providers and clients provided a number of suggestions for practices and procedures that could facilitate IPV services. These suggestions also can be viewed as applying to the organizational, provider, or client levels, and Table 1 shows how these suggestions directly address many of the barriers to care identified through this study.

Organizational or structural facilitators—Many staff participants felt the need for structural changes at the organizational level, such as instituting policies and protocols about screening for and addressing IPV. Although some agencies have informal protocols, few, if any, had formalized these processes. Furthermore, clients and staff suggested that more frequent and detailed screening for IPV should be dictated by ASO policies, and that tools

or protocols should be created to guide the screening process. Many clients reported that they may have disclosed their experiences of IPV to ASO service providers if staff had asked them specific questions about their relationships

> "[Staff] need to ask more questions about past relationships and abuse… The staff need to dig into their patients' relationships, if their patients are willing to tell them. They should try to find out about the relationships and figure out what they can do to help."
>
> – Client Interview 201

In addition to the implementation of new policies, staff also suggested that organizations should prioritize IPV as a serious health issue affecting their clients. One provider suggested that organization leadership discuss IPV more regularly in staff meetings to emphasize the importance of addressing IPV. Several staff members suggested prioritizing IPV by appointing an IPV expert in each agency, who would be responsible for maintaining awareness of available resources and best practices, as well as providing training for other staff.

Strengthening referral systems to other relevant organizations was described as a key component of prioritizing IPV. Although many staff members had information about a domestic violence hotline, participants expressed the need for active referrals that acknowledge the sensitivity of the issue.

> "[What] needs to happen is for the HIV folks to get to know the domestic violence folks in their community, so that they can make an … active referral to an actual person and not a passive referral. [Giving] somebody a bunch of numbers is not making a referral."
>
> – Staff Interview 101

Clients also suggested that ASOs offer different types of services to address the diverse needs of individuals. While some clients reported only feeling comfortable discussing IPV in private, one-on-one settings, others appreciated women's groups through which they could learn about others' experiences. Consequently, providing multiple venues for discussing IPV is essential to appealing to as many clients as possible.

Provider-level facilitators—Most ASO staff participants felt that increasing training for ASO workers was the most important way of improving awareness of and services for IPV within the ASO context. Several participants suggested that in the case of IPV, training should not only be provided for case managers, but also for all staff members from receptionists to janitors and other staff, because any staff member may be in a position to recognize problems and should know what action to take.

> "It should certainly be a programme-wide training; that would be the preference. Because the way it works is that, you know, frankly it could be the, the chef who hears something, and if they aren't trained, then it's a missed opportunity."
>
> – Staff Interview 103

When asked about structure of such a training session, most staff agreed that training should be interactive and applied as well as integrated into training and conversations on other related topics. Cost is a key concern for many ASOs and funds for sending staff to external training sessions are very limited.

Clients also stressed the importance of positive working relationships with ASO staff members when describing their ideal service interaction or positive past experiences with providers. In particular, clients suggested that staff build rapport and improve listening skills in their client interactions. These skills would be relevant to many dimensions of ASO work, in addition to IPV.

> "You gotta be comfortable with the person in order to tell them what's going on. So after the [staff] has earned the patient's trust, like by asking, "How are you feeling today?" or "What's going on today?" Then ask questions about the relationship."
>
> – Client Interview 201

Clients also emphasized the importance of trust in staff and the ability to rely on providers in crisis situations. Specifically, clients found comfort in developing a safety plan with ASO staff and in knowing that a familiar provider would support them in a time of crisis. Finally, clients expressed that ASO staff could encourage IPV disclosure by assuring confidentiality. Clients felt that staff should not only emphasize the confidential nature of their conversations, but also ensure that confidentiality is honoured, as described by this client: "[Case managers should] assure the women that what they say is between them, the person, the individual and the case manager, and it goes no further" (Client Interview 217).

Client-level facilitators—Clients and providers both highlighted the importance of empowering clients to overcome feelings of fear and shame and to actively seek services. Participants suggested the implementation of support groups that would encourage women to share their experiences with IPV by creating a safe and caring environment where women will feel comfortable communicating sensitive and deeply personal information.

> "A lot of times the victims do feel isolated and alone. So I think if they see that the various support systems that they have shown interest in that specific area – other than their HIV – because that's not, it's not a separate area. You're dealing with the whole person."
>
> – Staff Interview 111

At the same time, group settings may not be appropriate for all clients, and participants recommended that providers seek all opportunities to support and empower clients in their interactions.

Discussion

This study utilized qualitative data to assess the extent to which ASOs address IPV among women living with HIV. While IPV presents a significant public health problem in general, IPV may have particularly severe consequences for women living with HIV. Previous research has shown that women with HIV are more at risk for experiencing IPV than

women who do not have HIV, and women living with HIV who experience IPV may be at higher risk for some negative health outcomes compared to HIV-positive women who have not experienced IPV (Illangasekare et al. 2012). These interviews revealed women's perspectives on how an abusive partner may actively or passively interfere with a woman's HIV care and prevent her from accessing services for IPV. But while IPV may impact HIV care, little is known about the ability of ASOs to address IPV. In response to this gap, this article reports on key challenges and barriers to addressing IPV at the organizational, provider, and client levels and potential facilitators to addressing these challenges.

Clients and staff expressed that ASOs have the unique opportunity to provide comprehensive and holistic care by addressing IPV. The staff interviewed in this study indicated a need for more staff training and more clear policies about IPV to improve screening for and services related to IPV. From the client perspective, participants emphasized a desire for more screening of and discussion about IPV in a variety of settings (group-based and one-on-one). These client suggestions align with the needs highlighted by staff since screening about and awareness of IPV could be increased greatly through training and policies. Many client and ASO staff suggestions could be integrated into existing programmes rather than require additional funding and time. In fact, staff and clients stated that the incorporation of IPV-related messages into other programmes and protocols would be the most effective way to encourage women to discuss their experiences with IPV. However, it is important to note that clients and staff suggestions differed based on their unique perspectives. While clients were more focused on what the client experience should be like, staff emphasized the structural or operational changes that may allow for a change in the client experience, like increased training or improved policies on IPV. And while the staff participants were interested in knowledge-based and operational changes, clients highlighted the importance of inter-personal relationships that were based on trust and empowerment of the client. Given participants' experiences and personal relationships, trust and disclosure in the ASO setting may be particularly challenging for many clients that have experienced IPV. Unless staff have a strong understanding of the unique needs of this client population, increased knowledge and improved policies may fail to substantively improve services. Given the different perspectives of clients and staff, ASOs should consider involving women with histories of IPV in programme and policy development and engaging clients to participate in staff training. In cases where ASOs must adhere to national regulations, such as regarding the confidentiality of client information, staff should be carefully trained not only on the policies themselves, but also on how those policies can be communicated to patients in order to promote honest and trusting relationships.

Although this study offers valuable insight into the barriers and facilitators to addressing IPV in ASOs, these findings should be considered in light of the following limitations. The sampling strategy for this study was intentionally focused on saturation and is not necessarily representative of the experiences and opinions of all ASO staff and clients. As such, findings are best used to inform the development of hypotheses and questions for future research. Additionally, it was not feasible to conduct participant validation of the findings with the participants of this study. However, preliminary findings were reviewed by staff at the umbrella organization, AIDS Connecticut, and the findings have been shared broadly with the member ASOs.

These findings provide support for several future directions in research and practice. Awareness of the prevalence and impact of IPV on women living with HIV is essential in treatment and care settings that provide services for this population. At a minimum, these agencies need policies and procedures for screening and referral as well as staff training on how to sensitively address IPV. Identifying or developing relevant training material and programmes for IPV and HIV should be an important goal for ASOs. To date, we are unaware of specific empirically-supported interventions for addressing IPV in women living with HIV, though a few empowerment-based interventions for women in violent relationships have been implemented (Hien et al. 2010, Logan et al. 2002, Sikkema et al. 2010). Furthermore, the National Network to End Domestic Violence has recently developed a curriculum for providers to address the co-occurrence of HIV and IPV, entitled "The Intersection of Domestic Violence and HIV/AIDS". As a next step, these approaches should be adapted or new interventions should be developed to address the specific needs of women living with HIV. Additionally, collaboration between ASOs and IPV service providers will facilitate care for women experiencing both HIV and IPV. Ultimately, policies and procedures at the provider, organization, and community levels are needed to improve the wellbeing of clients by protecting and empowering women as well as reducing the stigma of IPV and HIV.

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What is known about this topic:

- The co-occurrence of HIV and IPV is a significant public health problem, and women living with HIV experience higher rates of IPV compared to those without HIV

- IPV can have a negative impact on the mental health of women and on the treatment adherence of women with HIV

- Little is known about the capacity of ASOs to recognize and address IPV

What this paper adds:

- Describes key challenges and barriers to addressing IPV at the organizational, provider and client levels and potential facilitators to addressing these challenges

- Demonstrates how staff and client priorities for improving IPV programmes may differ

Table 1.

Key themes in barriers to and suggestions for ASOs in addressing IPV among clients

Barriers to Addressing IPV	Suggestions for Improving ASO Services
Structural or organizational level issues	
• Lack of funding and role of funding [**] • Lack of coordination of care [**] • Lack of policies and protocols about IPV [**] • Lack of IPV-related services [***]	• Prioritizing IPV within agencies [**] • Creating policies and screening protocols [**] • Ensuring adequate structure and types of services offered [***] • Strengthening referral systems [*]
Provider level issues	
• Lack of training related to IPV [**] • Poor relationships with client [***] • Confidentiality concerns [***]	• Training providers to screen for and manage IPV-related issues [**] • Emphasize and respect confidentiality [***] • Improving client/staff relationships [***]
Client level issues	
• Stigma [*] • Fear and shame, low self-esteem [*] • Lack of awareness about IPV and IPV resources [***] • Complex client profiles and co-occurring issues [*]	• Building awareness in community and among clients [*] • Empowering clients and encouraging social support [*]

Note: These key themes were raised during in-depth interviews with staff and clients. Specifically, the research origin of the barriers and suggestions is denoted with asterisks:

[*] Barriers and suggestions discussed by both clients and staff.

[**] Barriers and suggestions discussed by staff only.

[***] Barriers and suggestions discussed by clients only.