Addressing Relationship Dynamics and Intimate Partner Violence in PrEP Services

PrEP Learning Network Meeting
November 2019

Rose Wilcher
FHI 360
1 in 3 women worldwide have been beaten, coerced into sex, or otherwise abused in their lifetimes.

1 in 4 girls’ first sexual encounter was unwanted.

1.5 is the increased likelihood that women who experience intimate partner violence will acquire HIV.

47% of males living with HIV aged 15 and older are on ART, compared with 60% among females.

Exposure to GBV, particularly IPV, is associated with lower ART use, half the odds of self-reported ART adherence, and significantly worsened viral suppression among women.

Having gender inequitable beliefs or endorsing harmful gender norms – particularly norms sanctioning violence against and the control of women by male partners – decreased the odds of ART use among PLHIV.
High prevalence of past-year IPV, among ever-partnered women (15-19 years)

Decker, 2014
Violence against KPs is prevalent, frequent, and often severe

**DOMINICAN REPUBLIC**
46% of trans women reported experiencing trauma since the age of 14, including sexual abuse (25%), psychological abuse (32%), torture (18%), and attempted murder (20%).

**UKRAINE**
43% of women who inject drugs reported physical violence by police and 13% reported sexual violence by police in their lifetime.

**CAMEROON**
60% of FSWs experienced physical or sexual violence in their lifetime.

**INDIA**
50% of female sex workers (FSWs) reported physical violence and 77% reported sexual violence in the past six months.

**THAILAND**
69% of MSM and 89% of trans women experienced emotional, physical, or sexual violence in their lifetime.

**PERU**
42% of male sex workers reported experiencing violence, including physical (25%), emotional (27%), and sexual violence (16%), from intimate partners and clients in the past six months.

**KENYA**
57% of PWID, 44% of FSWs, and 24% of MSM were arrested or beaten by police officers in the past six months.

**SOUTH AFRICA**
51% of FSWs reported physical assault and 22% reported sexual assault or rape in the past 12 months.
How does IPV affect PrEP use?

- Intimate partner violence associated with:
  - Lower PrEP uptake¹
  - Increased PrEP interruption²
  - Lower adherence to PrEP use³,⁴

- Qualitative research
  - IPV resulted in stress and forgetting to take pills, leaving home without pills, and partners throwing pills away³

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How do relationship dynamics affect PrEP use?

• Woman can use oral PrEP without a partner’s knowledge or agreement

• However…
  – Women often want the support of male partners
  – Women have more difficulty using PrEP consistently if:
    - Their partner is unsupportive of using it
    - They are experiencing partner abuse

Continuum of partner disclosure

Figure 1. Study participants’ most common reasons for disclosing or not disclosing PrEP use to sexual partners, across both sites (darker shading & bigger circles depict more common responses)

Non-disclosure (continuum) Disclosure

Passive
- I’m not ready to explain it to him
- Study counsellor said it was best
- There is just no way to hide PrEP pills from him
- He thinks I’m taking contraceptives
- If things get serious I will tell him
- I don’t want secrets
- There is nothing to hide
- I feel proud... we are bringing change
- PrEP should be all over the world...

Active
- Fear
- He will say you have other partners or you don’t trust me
How do we integrate violence prevention programming into PrEP programming?

• Clinic-based violence detection and response
  – WHO clinical guidelines
  – CHARISMA
  – Couples counseling

• Community-based violence prevention
  – Group-based workshops for men and women
  – Community mobilization
  – Empowerment training for women
  – Economic interventions
  – Engage community leadership structures
Gender Equality and Gender-Based Violence Priorities for USAID’s PEPFAR Programs
Gender, GBV, and the Clinical Cascade

**Prevention**
- Evidence-based HIV Prevention Approaches
  - Harmful gender norms and inequitable attitudes about gender put individuals at risk for HIV and serve as a barrier to uptake of HIV prevention, testing, and care and treatment services.
  - Violence is a barrier to PrEP initiation and adherence. Qualitative evidence suggests that violence can also occur as a result of PrEP use.

**Testing**
- Access HTS
  - Violence and harmful gender norms inhibit one’s ability to access testing services and disclose their status. Many people report fear of violence and/or abandonment if their partner learns their status.

**Care and Treatment**
- Initiate on ART
  - Harmful gender norms often inhibit men’s health-seeking behaviors. Violence is associated with reduced linkage to HIV care services and initiation on ART.
- Adhere to ART & viral suppression
  - Women who experience violence are less likely to adhere to treatment and achieve viral suppression. Violence is also associated with reduced ART adherence among adolescents, transgender women, and drug users.

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**Barriers to Epidemic Control**

- Prevention
- Testing
- Care and Treatment

**Evidence-based HIV Prevention Approaches**

**Initiate on PrEP**

**Access HTS**

**Initiate on ART**

**Adhere to ART & viral suppression**

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**USAID**

FROM THE AMERICAN PEOPLE
Gender, GBV, and the Clinical Cascade

**Prevention**
- Evidence-based HIV Prevention Approaches
  - Initiate on PrEP

**Testing**
- Access HTS
  - Survivors identified during self-testing, index testing, and PN services, and provided and/or referred to HIV treatment initiation and GBV response services.

**Care and Treatment**
- Initiate on ART
  - Adhere to ART & viral suppression
  - 95%
  - Providers identify survivors via routine and/or clinical enquiry during ART initiation and routine clinical care. Survivors offered support and provided with or referred to GBV clinical care.
  - Improve quality of post-violence clinical care services in care and treatment sites.

**Our Solutions: Addressing Violence and Inequality Across the Cascade**

- HIV prevention interventions that integrate violence prevention and link to clinical cascade.
- Survivors identified and provided support and referrals to GBV response services to increase PrEP adherence.
Addressing intimate partner violence (IPV) in the context of index testing, PN services, and PrEP.

Providing post-violence clinical care services in HIV care and treatment sites.

Improving linkage between community-based prevention interventions and clinical post-GBV care services.

Improving monitoring of GBV prevention and response activities.
Addressing IPV in index testing, PN, & PrEP

• All HIV testing sites must conduct routine enquiry for IPV (sometimes referred to as GBV screening) for clients who are offered partner notification services.

• All PrEP sites must conduct routine enquiry for IPV with all clients.

• After conducting routine enquiry for IPV, sites must then offer appropriate support and referrals to GBV response services.
The **minimum requirements** that must be in place for sites to conduct clinical and routine enquiry are:

- **Providers** offer first-line support (LIVES)
- A protocol/SOP for conducting routine enquiry
- A standard set of questions where providers can document responses
- Providers are trained on how to ask about IPV or sexual violence
- Providers only ask about IPV or sexual violence in a private setting, confidentiality ensured
- A process for offering referrals or linkages to other services is in place
First-line Support: LIVES

First-line support is the immediate care given to a GBV survivor upon first contact with the health or criminal justice system.

- **Listen**
  - Listen closely with empathy, not judging.

- **Inquire about needs and concerns**
  - Assess and respond to the survivor’s needs and concerns – emotional, physical, social, and practical.

- **Validate**
  - Show that you believe and understand the survivor.

- **Ensure safety**
  - Discuss how to protect the survivor from further harm.

- **Support**
  - Help the survivor connect to services, social support.
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Integrating Intimate Partner Violence “Screening” into HIV Clinical Settings
Learning Outcomes

➢ Describe the different approaches to screening for IPV
➢ Describe the objectives of conducting routine and clinical enquiry for IPV
➢ Describe the minimum requirements for conducting routine and clinical enquiry for IPV.
➢ Learn when and how routine enquiry for IPV should take place
➢ Learn what to do if a survivor discloses violence
Approaches to screening for IPV

1. Screening: A structured process used to detect a disorder or health condition.

2. There are 3 types of GBV screening/enquiry:
   - **Routine screening/enquiry** for all clients in a particular setting (e.g. asking all ANC patients or all HIV patients)
   - **Clinical Enquiry/Case Finding** - asking questions about IPV to patients who either disclose they have experienced violence, or patients who show signs and symptoms of GBV
   - **Universal screening** of all clients in all settings (clients are asked no matter what service they receive). Not recommended

Source: Adapted from WHO 2018 VAW Curriculum
What are clinical and routine enquiry for violence?

Clinical Enquiry for Violence.
• When a clinician asks only clients she/he suspects is experiencing violence or fears violence
• Clinical enquiry for violence is generally recommended over screening and routine enquiry UNLESS there are certain populations that may be at a higher risk of experiencing violence.

Routine Enquiry for Violence
• When a clinician asks all clients who present for specific services about experiencing violence or fears violence
• Routine enquiry for violence is only recommended in certain settings for populations that may be at a higher risk of experiencing violence, including:
  • ANC/PMTCT
  • Care and Treatment
  • HTS
Objectives of routine and clinical inquiry for IPV

1. Sensitively identify individuals experiencing IPV and connecting them to post violence services

2. Offer post violence services as below:
   - Support the survivor with brief empathetic first-line support (LIVES)
   - Referral of survivors to minimum post-GBV care package:
     - HIV post-exposure prophylaxis (within 72 hours of sexual assault)
     - Emergency contraception (within 120 hours of sexual assault)
     - HIV testing, counseling and linkage to treatment
     - STI testing and treatment
     - Treatment of acute injuries
     - Basic psychosocial counseling
     - Referrals to other services as appropriate

Source: Adapted from WHO 2018 VAW Curriculum
Minimum Requirements for Conducting CE and RE

- A protocol/SOP for the provision of post-GBV services
- A standard set of questions
- Providers are trained on how to ask about IPV or sexual violence
- Providers offer first-line support (LIVES)
- Providers only ask about IPV in a private setting, confidentiality ensured
- A system for referrals to post-GBV care services is in place

Source: USAID, Office of HIV/AIDS, Gender and Sexual Diversity Branch
Physical Violence:

› Within the last three months has anyone ever hit, punched, kicked, tried to strangle, slapped or hit you with something that could hurt or done anything else that hurt you physically?

Emotional Violence:

› Within the last three months has anyone threatened, cursed, insulted, done things that made you feel ashamed, kept you in a state of fear or humiliated you in front of others?

Sexual Violence:

› Within the last three months, has anyone forced you to have sexual intercourse with him/her even when you did not want to or forced you to perform other sexual acts you did not want to?
Remember, support, not diagnosis, is your most important role.

› “Many women experience problems with their husband or partner, or someone else they live with.”

› “I have seen women with problems like yours who have been experiencing trouble at home.”

› How are things at home? How is your relationship?

› Sometimes the people we care about hurt us. Has that happened to you?

› I am a safe person you can talk to if things are not all right at home.

Source: Adapted from WHO Clinical Handbook 2014
Asking about violence: direct questions

Direct questions (if patient responds “yes” to any, offer 1st line support/ LIVES)

› Are you afraid of your partner?

› Has your partner or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened?

› Does your partner bully you or insult you?

› Does your partner try to control you, for example not letting you have money or go out of the house?

› Has your partner forced you into sex or forced you to have any sexual contact you did not want?

› Has your partner threatened to kill you?

Source: Adapted from WHO 2018 VAW Curriculum
Counselling women on whether PrEP disclosure is safe

➢ Is your **partner aware** that you are thinking about using PrEP/have started using PrEP?

➢ If you told your partner you are thinking about using PrEP/have started using PrEP do you think he would **react supportively**?

➢ Are you **afraid your safety** would be at risk if you share your PrEP use with your partner?

➢ Do you think that your partner **may harm you if you** tell him that you are thinking about using PrEP/have started using PrEP?
Lessons learned by PrEP providers

➢ Should not coerce clients into taking PrEP but rather you should help her make an informed decision

➢ Can repack the medication in an envelope (or other discrete manner) rather than having them carry in the distinct tin

➢ Take time with clients in order for them to be able to open up

➢ Some clients will confidently take PrEP and hide it in the house

➢ Clients whose partners visit once in a while will not disclose they are on PrEP

➢ Only a few male sexual partners are aware their partners are on PrEP (in marriage, they won’t even talk about condoms)

➢ Abstinence/Use of condoms during the seven days lead up to full efficacy of PrEP is not always feasible (for example for those in marriage)
Example of Pathway for Care for IPV

Violence suspected but not acknowledged/disclosed

- Tell her about services
- Offer information on effect of violence on health and children
- Offer follow-up visit

Violence identified or disclosed*

Refer for other health care as needed

AND

Refer to available community support services

Specific mental health conditions?

*Some women may need emergency care for injury. Follow standard emergency procedures.

First-line Support
- Listen
- Inquire
- Validate
- Enhance safety
- Support

Care for the conditions that brought her there

Treat or, if possible, refer for specific treatment

Source: USAID, Office of HIV/AIDS, Gender and Sexual Diversity Branch
What should I do if she discloses violence?
First-Line Support

- First-Line support is a practical, survivor centered, empathetic counselling approach
- It is the immediate care given to a GBV survivor upon first contact with the health system
- It is conducted using the LIVES approach
- First Line Support IS NOT post GBV care
Support (through referrals)

➢ The goal is to support women to connect with other resources for her health, safety, and social support.

› Women’s needs are generally beyond what you can provide in the clinic.

➢ Remember: women face multiple barriers to reaching out for help.

› Your voice is important in encouraging her to seek support.

› Discuss the woman’s needs with her, and share sources of help.

› If you offer a referral, also offer to help make a call on patient’s behalf if it would be more comfortable for her

Source: WHO Clinical Handbook 2014
Documentation

➢ The provider should endeavor to document all key information the patient tells her/him, particularly to ensure that the survivor does not have to repeat her story again and again (leading to re-victimization).

➢ We recommend that providers use a GBV register and medico-legal form. There are standard forms available in the facilitation guide of the GBV Quality Assurance Facilitation Guide, available at http://resources.jhpiego.org/resources/GBV-QA-tool, for adaptation at specific country level.
Know your setting! Referral networks & policy context
Establishing referral pathways

- Identify and map available services or organizations
- Develop tools for monitoring referrals and coordination
- Create a directory list
- Establish informal or formal agreements with focal points
- Establish referral pathways
Establishing referral pathways

- Identify, map and confirm (via a phone call or visit) available services such as:
  - Police/Law enforcement
  - Justice services
  - Social Services
  - Emergency shelter
  - Economic/Livelihood support
  - Child protection services

- Create a referral directory to keep track of community resources (job aid available)

- Establish informal or formal agreements and personal contacts with service providers

- Specify how you will find out if the woman reaches the referral resource

- Monitor referrals and coordination mechanisms
Types of Referral

- Social Services
- Health
- Police
- Child protection
- Livelihood/economic support
- Justice
Offer her a warm referral

➢ Reduce barriers to women accessing services (e.g. help her identify a means of transport)

➢ Explain why the service can be helpful for the patient’s specific need

➢ Actively help women access the referral
  ✓ Offer to make a call on her behalf
  ✓ Offer to make a call with her
  ✓ Offer private office space for her to make the call

Source: Adapted from WHO 2018 VAW Curriculum
Key messages

➢ Routine enquiry may reduce women's needs for health services and may save time and resources by helping providers understand and address violence as an underlying reason behind PrEP uptake.

➢ Routine enquiry can help identify survivors early, before violence escalates impeding their PrEP access, uptake and use.

➢ Always keep the survivor’s best interests first – think safeguarding during PrEP consultation, referral, limit risk of further violence occurrence or retraumatization.
Additional Resources

• WHO Clinical Handbook: Care for Women Subjected to Intimate Partner Violence and Sexual Violence (2014)


• WHO Violence Against Women Training Curriculum (2018, forthcoming)
THANK YOU

CONTACT US:
www.lvcthealth.org
Background

- AGYW engaging in transactional sex and young FSWs aged 18-24 face high levels of stigma and discrimination when accessing HIV services, thus increasing their vulnerability.

- The majority of young FSWs and AGYW engaging in transactional sex report client-initiated gender-based violence (GBV).

- Violence prevention and response is a critical measure to addressing vulnerability amongst key and priority populations (and improving likelihood of effective PrEP use).
GBV Program Components

- Routine GBV screening and provision of violence prevention tips by peer educators (PEs) and peer navigators (PNs) in hotspots and safe spaces
- GBV screening and referrals by Crisis Response Teams (CRTs)
- Screening of AGYW and Young FSWs 18-24 years in DICs, hybrid facilities, mobile outreach and moonlight and adolescent-friendly safe spaces
- Victim support units - screening and provision of PEP start dose by trained law enforcers
- Community - psychosocial support and case conferencing by social workers
GBV Minimum Service Package

- Psychosocial counseling (empathetic listening, inquiring about needs and concerns, experience sharing, validating, and ensuring safety)
- Treatment of injuries
- HIV testing and counseling services and referral to care and treatment or PrEP, as appropriate
- STI screening and treatment
- Post exposure prophylaxis (PEP) within 72 hours of sexual exposure
GBV Minimum Service Package (cont.):

- Emergency contraception within 120 hours
- Referral and linkage to other services (child protection, legal counsel, police, psychosocial support, emergency shelter)
Outreach Teams

- Peer educators, peer navigators, peer mobilizers
- DREAMS Ambassadors
- Trained community structures, i.e. Crisis Response Teams, DIC advisory committees, community policing, child protection committees
- Healthcare workers, social workers
Crisis Response Teams

- A community-led rapid response system that responds to incidents of violence in the shortest period
- Located in clustered hotspots (56)
- Comprised of bar and rest house owners, PEs, PNs, police, community leaders
- First point of contact at the hotspot level; provide hands on practical and emotional support to victims of violence
Crisis Response Teams

- **Roles of CRTs**
  - Advocate for reduction of stigma and discrimination against key population group members
  - Support PEs and PNs to document all incidences of violence
  - Negotiate for release of victims that have been unlawfully arrested
  - Provide psychosocial counselling
  - Provide referrals and linkages to other services
Engagement of law enforcers

- 27 law enforcers trained from EpiC districts
- Participate in monthly meetings for PEs and PNs
- Law enforcers provide information on rights during meetings, including how and where to report violence
- Follow-up cases to ensure justice has been provided
- Involvement includes membership in DIC advisory committees, CRTs
Male engagement efforts

• Through CFSWs, PEs, and PNs

• DIC advisory teams - participate in violence prevention and behavior change programs - before, once violence begins, and in preventing the recurrence of violence

• Engaging opinion leaders to support violence prevention efforts – ensuring an enabling environment where AGYW can access stigma-free services – safe places
## FY19 GBV – Machinga & Zomba

( FSW 18-24 Years )

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<th>Post GBV Care</th>
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<td>25</td>
<td>14</td>
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<tr>
<td>Total</td>
<td>103</td>
<td>69</td>
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Challenges / Gaps

- Intimate partner violence normalized and justified in most communities, as such FSWs and AGYW are reluctant to report IPV
- Limited reporting by hybrid health facilities
- Limited capacity to conduct forensic reports for VSU referrals
- PEP not provided in some police VSUs despite policy allowing initial dose
- Inadequate capacity by outreach teams to provide mental health support
Way Forward

- Support capacity building of HCWs in GBV screening, care, support and documentation
- Include mentorship package for PE & PN to promote more openness among peers for increased documentation of GBV
- Scale up group counselling to allow victims to connect with others who have been through similar situations
- Continue engaging partners specialized in psychosocial counselling
Thank You