

HIV AND INTIMATE PARTNER VIOLENCE AMONG ASIAN AMERICAN AND PACIFIC ISLANDER WOMEN

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Addressing the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities – a federal interagency report in 2013,¹ followed by an update in 2014,² have brought the disproportionate impact of HIV on women into sharp focus. This Fact Sheet raises awareness about the nexus between HIV and IPV, contextualizes cultural barriers, and analyzes factors contributing to elevated risk for Asian American and Pacific Islander women and girls. It provides trauma-informed, gender-sensitive recommendations for increased coordination between service providers.

HIV and Intimate Partner Violence (IPV) share a common set of factors and considerations that place women and adolescent girls at risk. Asian American and Pacific Islander (AAPI) women and girls face unique obstacles as they operate in a social sphere shrouded in silence about HIV and IPV, surrounded by stigma and hampered by the lack of data and investments into tailored, gender-based strategies. Both biological and societal vulnerabilities impact AAPI women and girls' ability to stay healthy, get tested and access treatments and supports.

Intimate Partner Violence

Gender-based violence, including domestic violence, incorporates norms that place women's health at risk by gaining credibility from social and cultural inequities. Gender-based violence and oppression are tools to insulate gender norms and expectations from change. Intimate partner violence includes physical violence, sexual violence, threats of physical or sexual violence, stalking, psychological aggression (including coercion) and economic abuse by a current

21 to 55%
of Asian women have experienced intimate physical and/or sexual violence³

86%
of API women living with HIV contracted it through heterosexual sex⁴

Only 17%
of API women have ever been tested for HIV, the lowest of all groups⁵

¹ Interagency Federal Working Group. *Addressing the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities*. September 2013.

www.whitehouse.gov/sites/default/files/docs/vaw_master_report.pdf

² Office of Federal AIDS Policy, White House Advisor on Violence Against Women, White House Council on Women and Girls. *Update on Efforts to Address the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities*. October 2014.

www.whitehouse.gov/sites/default/files/docs/hiv_vaw_grhd_report.pdf

³ Yoshihama M, Dabby C. *Facts & Stats Report: Domestic Violence in Asian and Pacific Islander Homes*, Updated 2015. Asian Pacific Institute on Gender-Based Violence. 2015.

<http://www.api-gbv.org/download/Facts.Stats-APIIDV-2015.pdf>

⁴ Adih W, Campsmith M, Williams C, Hardnett F, Hughes D. Epidemiology of HIV among Asians and Pacific Islanders in the United States, 2001-2008. *Journal of the International Association of Physicians in AIDS Care*. 2011.

⁵ Hahm H, Song I, Ozonoff A, Sassani J. HIV Testing Among Sexually Experienced Asian and Pacific Islander Young Women: Association With Routine Gynecological Care, *Women's Health Issues* 19:279-288. 2009.

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or former intimate partner. Among AAPI women, IPV can take various forms including abuse by family members and in-laws. While violence can occur in any relationship, this Fact Sheet primarily focuses on IPV in heterosexual relationships as women are disproportionately impacted by gender-based violence.

HIV and AIDS

Human immunodeficiency virus (HIV) can lead to acquired immunodeficiency syndrome, or AIDS. Once an individual contracts HIV, they have it for life. While there is no cure, HIV can be controlled with antiretroviral therapy. HIV is transmitted by certain fluids—blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, and breast milk—when they come into contact with a mucous membrane or damaged tissue.

AAPI Women and Girls at Risk

Exposure to violence can increase the risk of HIV infection and HIV infection can lead to violence. Some AAPI women and girls are at particular risk for HIV infection due to biological and societal factors, including age, immigration status and migration patterns, exposure to violence and conflict, and sexual and gender identity.

Youth and Young Adults

Young adults comprise the majority of new HIV infections, raising concerns about violence across the lifespan and the impact of sexual violence victimization at an early age. Adolescent girls are at heightened risk for transmission because their immature genital tracts are more prone to tearing, increasing their risk of contracting HIV. Forced sexual intercourse can tear the vagina, increasing risk of HIV transmission. Culturally sanctioned practices such as early forced marriage or survival strategies such as being forced to marry one's rapist can elevate HIV risk factors for AAPI girls/young adults. Social pressures that render sexual health taboo contribute to ignorance about sexuality and safe sex practices among young AAPIs.

Immigrants

Immigration status can have a marked impact on health, including ability to access HIV testing and care and opportunities for AAPI women to work and support themselves economically.

AAPI immigrant women may experience sexual violence in their home countries and in detention centers, increasing the risk of HIV and other sexually transmitted infections. AAPI immigrant women may arrive in the U.S. on derivative visas, with their legal status dependent on their husband's and limited options to support themselves, lessening their relationship power and ability to practice safe sex. Depending on her immigration status, an AAPI woman may fear getting tested or be unable to access care due to immigration-based restrictions in federal and state funded health programs. AAPI women married to men who travel back and forth to their home countries have additional infection risks arising from transnational

husbands who may – unbeknownst to them – have a second family or engage in sex tourism and therefore, infect them.

Trafficked or Fleeing Conflict

AAPI women may arrive from conflict zones, where sexual violence is used as a systematic method of targeted gender-based violence. Refugee women and girls fleeing conflict and disaster zones and arriving from refugee camps frequently experience physical and mental trauma as a result of sexual assault and may be further stigmatized by their families and blamed for subsequent HIV infections. AAPI women may be trafficked across borders against their will and exposed to repeated sexual violence and unprotected sex with infected men.

LGBTQ

Among AAPIs, there is a strong cultural presumption of heterosexuality that along with economic challenges, results in substantial barriers to testing and care. Transgender individuals face high rates of unemployment and are four times more likely to live in poverty than the general population. Low economic status can contribute to sex work which can increase exposure to violence and assault, thereby influencing HIV risk.

Nexus Between HIV and IPV

Gender, patriarchy and culture interact in complex ways that influence a woman’s physical health, relationship dynamics and the degree of control within her relationships. AAPI women’s risk of contracting HIV and exposure to violence is influenced by these social constructs, biology and resulting risk factors.

A woman’s risk of contracting HIV depends on the mode of sexual contact (highest for anal), presence of trauma or abrasions, viral load of the man and her health. Eighty-six percent of AAPI women living with HIV contracted it through unprotected sex with a male partner. Thus, an AAPI woman’s risk depends on her male partner’s risk behaviors and viral load.

Relationship Power

Relationship power conceptualizes the degree of power people have within relationships. Even in a nonviolent relationship, societal constructs can lead to a power imbalance. Relationship power can have a marked impact on health and risk for contracting HIV, primarily through the ability to negotiate condom use and safe and consensual sexual activity. AAPI women experiencing violence may be unable to use condoms for fear of being labeled promiscuous. Batterers may force sex or use economic coercion to prevent partners from purchasing condoms. These coercive tactics place AAPI women’s health at risk by exposing them to sexually transmitted diseases and resulting physical and emotional trauma.

AAPI women are 4x more likely to have an STI than their male counterparts ⁶

HIV+ women are twice as likely to have experienced IPV ⁷

⁶ Hahm CH. *Understanding STDs and Health Disparities in Asian Pacific Islander Communities*. Boston University School of Social Work. 2009.

⁷ Gielen, AC, et al. HIV/AIDS and intimate partner violence: intersecting women’s health issues in the United States. *Trauma, Violence, & Abuse*. 2007. 8(2):178-198.

Stigma, Privacy and Shame

Sexual health and relationship dynamics are highly stigmatized topics among AAPI women and girls. The silence—both in families, among communities and by providers—can foster an environment of increasing risk. Cultural barriers, while differing amongst the 40 different ethnic groups that comprise AAPIs, share common traits that hamper conversations about sexual health and relegate relationships to the private sphere. Stigma about contracting HIV can be personally and socially isolating, causing an infected AAPI woman to hide her status from family and friends. For AAPI women in coercive relationships, disclosing HIV status can cause violence. Family and community members may blame a victim for HIV infection, resulting in further isolation. Misconceptions about AAPI women’s risk among providers as well as fear of the consequences of testing positive can lead to forgoing testing. Lack of privacy in an extended family home, especially where there is IPV, can mean an extra layer of surveillance of a woman’s activities and habits, making it more difficult to adhere to a treatment regimen.

Differing Dynamics of Domestic Violence

Domestic violence in some Asian communities can include physical, sexual and emotional abuse by in-laws. What this can mean is that women can be infected by male in-laws and/or husbands whilst female in-laws may pressure survivors into silence and block help-seeking. As such, the connection between IPV and HIV needs to extend to address the dynamics or risks caused by multiple perpetrators in the home.

Impact of Violence and Trauma

Experiencing trauma has a marked impact on physical health and disease response. HIV status can be both a cause and effect of violence. Women who have experienced violence (physical and sexual) are nearly four times more likely than their peers to engage in risky sexual behavior. They are also more likely to have been forced into sex with someone who is HIV positive or used drugs. Women with HIV who have suffered a recent trauma are four times more likely to experience virologic failure – a condition where drug treatment does not work and can lead to HIV-related illnesses and drug resistance, than women who have not experienced violence.⁸

Trauma and posttraumatic stress disorder (PTSD) disproportionately affect HIV-positive women. Psychological trauma has been increasingly associated with high prevalence and poor outcomes of HIV in women. For example, the rate of recent PTSD among HIV-positive women is 30%, which is over five times the rate of recent PTSD reported in a national sample of women.⁹

The Women’s HIV Program (WHP) at the University of San Francisco has pioneered trauma-informed primary care for women living with HIV. Dr. Edward Machtinger, WHP’s Director states: “Women who report experiencing trauma often do not have the power or self-confidence to protect themselves from acquiring HIV. Once infected, women

⁸ Bardi J. *Trauma Drives HIV Epidemic in Women*. University of California San Francisco. 2012. <https://www.ucsf.edu/news/2012/03/11726/trauma-drives-hiv-epidemic-women>

⁹ Machtinger EL, Wilson TC, Haberer JE, Weiss DS. Psychological trauma and PTSD in HIV-positive women: a meta-analysis. *AIDS Behavior* 2012 Nov; 16(8):20191-100.

who experience ongoing abuse are often not in positions of power to effectively care for themselves or to insist that their partners protect themselves. Effectively addressing trauma has the potential to both improve the health of HIV-positive women and that of the community.”¹⁰

What Does this Mean for Providers and Advocates?

Advocates addressing domestic violence and medical providers serve an important role in assessing risk, counseling AAPI women and girls and connecting them to both safety and health care, including testing and treatment. We recommend that advocates in community-based-organizations, providers and testing clinics should:

1. Cross-educate and be aware of the intersections, risk factors and associated dynamics facing AAPI women.
2. Understand the role that immigration status and connection to community can play for AAPI women, including whether they can seek or afford care and whether they are able to contact police or victim advocates.
3. Understand the lifetime impact that exposure to violence has on risk behaviors, ability to take precautions and exercise relationship power. Exposure to violence and trauma during migration or as a child, for example, can influence HIV risk exposure.
4. Identify refugees who fled conflict or disaster zones where rape has been endemic for testing and treatment.
5. Develop trauma-informed interventions that take into account the diminished agency women and girls in abusive situations experience.
6. Recognize when to recommend an IPV survivor, and how to do so given safety considerations, for HIV/STI testing and post exposure prophylaxis (PEP), if needed.
7. Be familiar with pre-exposure prophylaxis (PrEP) and when it may be recommended, including for serodiscordant couples,¹¹ people who inject drugs, men who have sex with men, and heterosexual men and women who don't always use condoms with partners who are at substantial risk for HIV.
8. Work with IPV survivors to appropriately plan and consult HIV clinics for more information because partner notification and diagnosis can increase the risk of physical violence and coercion.
9. Establish partnerships between domestic violence service organizations,

¹⁰ For research on the intersections of trauma, violence and HIV, and policies on trauma-informed primary care for HIV-positive women developed by Dr. Machtinger and the Women's HIV Program team, go to <http://whp.ucsf.edu/>.

¹¹ Serodiscordant couples are couples where one partner is HIV positive and another is HIV negative. Daily doses of PrEP have been shown to reduce the risk of transmission between serodiscordant couples. For more information, see *Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2014 Clinical Practice Guideline*, US Public Health Service <http://www.cdc.gov/hiv/pdf/prepguidelines2014.pdf>.

healthcare providers and clinics to connect women to treatment and support immediately upon testing. Linkage to care is critical to managing HIV, maintaining good health and preventing transmission.

10. Develop a language access plan to provide language services – including interpretation and translation – to clients with limited English proficiency and partner with qualified medical interpreters who are proficient in the target language and to accurately interpret medical information.

These recommendations will serve to increase coordination between agencies providing HIV and domestic violence services to AAPI women and girls and establishing trauma-informed, gender-sensitive interventions that mitigate the sociocultural and gendered harms arising from the nexus of IPV and HIV.

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