Missed Opportunity for HIV Prevention Among a High-Risk Population of Women Experiencing Intimate Partner Violence

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INTRODUCTION

HIV pre-exposure prophylaxis (PrEP), a daily pill combining two antiretroviral agents, tenofovir disoproxil fumarate/emtricitabine (TDF/FTC), has been shown to be effective in preventing HIV transmission in men and women and is recommended for those at increased risk of HIV.[1] Experience of intimate partner violence (IPV) increases HIV risk for women,[2] and women receiving care in the Veterans Health Administration (VHA) experience substantial rates of IPV.[3] Given this risk and the availability of PrEP as a prevention tool in VHA, we sought to examine the association between recent IPV exposure disclosed to VHA providers through routine screening and HIV diagnosis, testing, and PrEP prescriptions among this population.

METHODS

Data were extracted from patient medical records through the VHA corporate data warehouse for all female patients routinely screened for past-year IPV across 13 VHA facilities between April 2014 and 2016 (for more information on study methods, see prior paper[3]). Additional abstracted medical record data included patient demographics (sex, age, race, ethnicity, marital status, and veteran status), VHA facility location, and HIV diagnoses, labs, and prescriptions. HIV infection (HIV+ status) was defined by ICD-9/ICD-10 diagnostic codes. HIV diagnosis data were extracted from the initiation of the VHA electronic medical record system in January 2000 to October 2018. HIV testing was assessed using lab test records for the 30-month period including the year prior to and 18 months following IPV screening. PrEP prescriptions were identified through prescription orders (i.e., that a prescription was filled) during the same 30-month period.

Bivariate analyses compared patients screening positive for past-year IPV (IPV+) to those screening negative for past-year IPV (IPV−) on the three outcomes: HIV diagnosis, HIV testing, and PrEP prescriptions. TDF/FTC prescriptions for those with an HIV+ diagnosis were excluded from analysis to avoid accounting for these drugs used for HIV treatment rather than prevention.

RESULTS

The study cohort included 8888 female patients with a recorded IPV screening during the observation period; 774 (8.7%) screened positive for past-year IPV (IPV+). Women in the sample ranged in age from 18 to 98 years, with a mean age of 45 years; nearly three quarters (73.2%) were under age 55. More than half (52.6%) of the patients were White, and over one third (38.2%) of them were Black/African American; 5.6% were Hispanic or Latina.

Over the 30-month observation period, 36% of patients screening IPV+ had received an HIV test within the VHA system, 3% had an HIV+ diagnosis, and only 1 (0.13%) had filled a PrEP prescription (Table 1). Women who had screened IPV+ were more likely than women who had screened IPV− to receive HIV testing (35.5% vs. 22.9%); there was no statistically significant difference between the two groups on HIV diagnoses or PrEP prescriptions filled.

DISCUSSION

Consistent with prior research,[2] we saw a higher prevalence of HIV among women reporting recent IPV; however, this difference was not statistically significant in our study, perhaps due to a small number of women in the cohort with HIV diagnoses (2.45% overall). The low rates of HIV testing (less than one quarter of the full cohort) and extremely low numbers of women with filled PrEP prescriptions among this

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Table 1. Relationship Between IPV Status, HIV, and HIV Prevention Strategies

	IPV− (*N* = 8114)	IPV+ (*N* = 774)	Total (*N* = 8888)	*p* value
	N (%)	*N* (%)	*N* (%)	
HIV testing (30 months)	1861 (22.95)	275 (35.53)	2136 (24.03)	< 0.001
HIV+ (ever diagnosed)	193 (2.38)	25 (3.23)	218 (2.45)	0.143
PrEP prescriptions =(30 months),among HIV−	9 (0.11)	1 (0.13)	10 (0.12)	0.595

vulnerable population of women experiencing recent IPV indicate a potential under-use of HIV prevention strategies. Our data did not include information on provider assessing additional HIV risk factors or counseling patients on the benefits of PrEP; however, findings indicate that there may be missed opportunities in HIV prevention strategies, especially as women who have experienced IPV can be generally accepting of using PrEP.[4]

This study highlights a population of women that may benefit from increased uptake of PrEP. Given that high adherence is important for PrEP efficacy[1] and the experience of IPV might increase the risk of low adherence to PrEP among women,[5] IPV+ women might need specialized counseling and safety planning, especially for those experiencing reproductive coercion,[4] when being prescribed PrEP. More research is needed to understand how we may best increase uptake of HIV prevention efforts among both patients and providers.

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Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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