The Intersection of Domestic Violence and HIV/AIDS Curriculum

The Intersection of Domestic Violence and HIV/AIDS Curriculum is a training tool designed to increase knowledge, understanding and competencies on the intersection of domestic violence and HIV/AIDS and to enhance collaboration between domestic violence advocates and HIV/AIDS service providers to improve services and increase the safety of the people we serve.

The Intersection of Domestic Violence and HIV/AIDS
National Network to End Domestic Violence © 2013
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NNEDV also wishes to acknowledge the amazing and vast contribution of:

Barbara A. Nissley, MHS – our expert and energetic curriculum developer who has nearly 20 years of experience in each of the DV and HIV/AIDS fields. Prior to consulting, Barbara was employed by the Pennsylvania Coalition Against Domestic Violence as a Training Specialist, conducting workshops, educational seminars and conference presentations for professionals in the fields of child welfare, education, mental health, Head Start, social work, and welfare. Prior to her work at PCADV, she was employed for 2 years by the South Central Aids Network in Harrisburg as a Prevention Educator. Since 1990, she has been a consultant trainer for the Pennsylvania Department of Health and the state Bureau of Drug and Alcohol Programs. She facilitates the 3 day course for HIV antibody test counselors as well as courses in Basic HIV/AIDS and STDs, Hepatitis and Tuberculosis. She developed a course for them on “Domestic Violence, Drugs and Alcohol and HIV/AIDS.”

National Advisory Committee on Domestic Violence & HIV/AIDS for their critical role in developing this curriculum and guiding our DV & HIV/AIDS project so that it can effectively meet the needs of DV and HIV/AIDS service providers and address the intersection of DV and HIV/AIDS. A list of Advisory Committee members and their bios are included after the acknowledgements section to highlight their level of expertise in the fields of domestic violence and HIV/AIDS.

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The National Network to End Domestic Violence (NNEDV) is a national membership organization made up of 56 state and territorial domestic violence coalitions.

In 2010 with funding from the MAC AIDS Fund, we developed a DV & HIV/AIDS project - led by our National Advisory Committee on DV & HIV/AIDS - to begin addressing the intersection of domestic violence and HIV/AIDS. In 2011, we developed this training curriculum for our members and their HIV training counterpart to provide training and technical assistance to improve service delivery and enhance collaboration on the ground.

To get more information on our DV & HIV/AIDS project, submit comments on the curriculum, or request more technical assistance and training on the intersection of domestic violence and HIV/AIDS, please email dvhivproject@nnedv.org or call 202-543-5566.

National Advisory Committee

Karma Cottman – Karma has worked in the domestic violence field since 1994. She currently serves as the Executive Director for the District of Columbia Coalition Against Domestic Violence. Previously, Karma was the Vice President of Policy and Emerging Issues at the National Network to End Domestic Violence (NNEDV) where she supervised NNEDV’s state coalition and transitional housing technical assistance projects as well as the Direct Assistance Initiative. Prior to joining NNEDV, Karma served as the co-director of the Florida Coalition Against Domestic Violence Rural Diversity Initiative. Karma serves on the steering committee of the Institute on Domestic Violence in the African American Community and the board of DASH, a Washington, DC transitional housing program specializing in services for women with substance abuse issues.

Dazon Diallo Dixon – Dazon is Founder and President of SisterLove, Inc., established in 1989; the first women’s HIV/AIDS organization in the southeastern United States. Dazon is a founding board member of SisterSong Women of Color Reproductive Justice Collective. She currently chairs the Fulton County HIV/AIDS Services Planning Council (Ryan White Council) and the Steering Committee of the Global Campaign for Microbicides. She also co-chairs the Community Advisory Board of the HOPE Clinic, Emory University’s HIV Vaccine and Microbicides Research Center. In 2001, Dazon opened a SisterLove program office in Mpumalanga - a rural South African Province near Johannesburg - where the project focus is capacity building and sustainable development for local women-led HIV/AIDS organizations.

Diana Echevarria – Diana is the Executive Director of North American Programs at M·A·C AIDS Fund and the former Manager of Corporate Contributions at Altria Foundation. Prior to overseeing Altria’s corporate sponsorship program, Diana managed the Doors of Hope Program, a national model grant-making program in partnership with the National Network
to End Domestic Violence. In this capacity, she oversaw all aspects of this multi-million dollar initiative, including translating emerging trends and service gaps into effective local, regional and national programs.

**Kathleen Griffith** – Kathleen (Kat) is the Policy Co Chair for the U.S. Positive Women’s Network - a national membership body of women, inclusive of transgender women, that advocates for policies and programs at the local, state, and national level that reflect the needs of HIV+ women and their families. In addition, Kat is also a member of the inaugural Illinois Alliance for Sound AIDS Policy, a group of selected state advocates who build capacity within the HIV community as well as identify policy issues and meet with legislators. Kat has been the President of the Client Advisory Board for her local AIDS Service Organization for two years, and is a member of NAPWA. She has programmed around the topic of HIV and spoken in schools, hoping to build the knowledge base of the younger generations, all the while building the esteem of the women and girls, both HIV positive and those who are negative, who are the most vulnerable. Kat was diagnosed with HIV in 1992.

**Rosie Hidalgo** – Rosie is the Director of Public Policy at Casa de Esperanza. She has worked in the movement to end domestic violence for the past 18 years. Rosie worked as an attorney at legal services programs for low-income families in New York City and in Northern Virginia. She then served as the Director of Programs and later as the Director of Policy and Research for the National Latino Alliance for the Elimination of Domestic Violence. Rosie also lived in the Dominican Republic for four years, until 2006, where she helped establish and coordinate a community-based domestic violence prevention and intervention network and worked as a consultant for the World Bank on social services reforms. Rosie received her undergraduate degree from Georgetown University and her law degree from New York University School of Law.

**Tam Ho** – Tam is the Director at M·A·C AIDS Fund where she oversees and sets the strategy for the Fund’s North American grant-making programs, including the Community Grants food and nutrition and housing programs. Tam also works with the Fund’s Executive Director of North American Programs to oversee grant-making in the areas of harm reduction and prevention, and MAF special initiatives. Prior to joining the M·A·C AIDS Fund, Tam directed Grant Programs at Feeding America, a national domestic hunger-relief organization, and worked with leading corporate funders to create signature branded grant programs to address hunger in the United States. Through her grant-making activities at Feeding America, she worked with several AIDS service organizations providing food and nutrition programs.

**Mark Ishaug** – Mark is the Executive Director at AIDS United and the former President/CEO of Chicago AIDS Foundation where he has helped establish AFC as the Midwest’s largest HIV/AIDS service organization and Illinois’ leading advocate for people with AIDS and the agencies that serve them. Mark joined AFC in 1991 as a policy analyst and worked as policy director and associate director before being appointed chief executive officer in August 1998. Under his leadership, the scope and reach of AFC has greatly expanded, and its grant-making, policy, prevention, and service coordination programs serve more people living with and at risk for HIV/AIDS than at any other time in AFC’s history. Mark currently serves as a Board Trustee for the National AIDS Fund and Funders Concerned About AIDS.
Shawn Lang – Shawn is the Director of Public Policy with the CT AIDS Resource Coalition (CARC). Shawn has been with CARC for 19 years. Her primary responsibilities are coordinating CT’s HIV/AIDS public policy and advocacy activities on the state and federal levels. Shawn co-chairs the AIDS LIFE (Legislative Initiative and Funding Effort) Campaign, Connecticut’s statewide AIDS policy group and was a member of the Red Ribbon Task Force on HIV/AIDS. She is the President of the board of the National AIDS Housing Coalition; is a member of the Communities Advocating for Emergency AIDS Response (CAEAR) Coalition; Co-chair of the CT HIV Planning Consortium; chair of the CT Lesbian/Gay/Bisexual/Transgender Leadership Council; and on the Executive Committee and Community Advisory Board of Yale’s Center for Interdisciplinary Research on AIDS. She has been an activist on issues impacting battered women; G/L/B/T communities; homelessness and HIV/AIDS. Other areas of expertise include coalition building, public policy, and community organizing.

Patricia Nalls – Patricia has since been a long-time activist for women in the Washington, DC community. After years of frustration at not finding appropriate support for women, girls, and their families, she founded The Women’s Collective (TWC), an AIDS service organization (ASO) dedicated to empowering women and girls living with and at risk for HIV/AIDS, with special emphasis on women of color. The Women’s Collective provides care, prevention and policy advocacy services that ultimately give women, girls and their families the hope they need to live healthy lives. Under her leadership, what began as a support group in her home is now an organization with a staff of over twenty five employees and countless volunteers. Patricia served as a consultant on a Health Resources and Services Administration (HRSA) Special Project of National Significance (SPNS) that focused on bringing women living with HIV/AIDS to the policy table where decisions were being made about their very lives. She has organized dozens of community focus groups, speak outs, and information sharing meetings, as well as assisted with the publication of various research and policy documents designed to target Policy makers to assist them in better understanding the needs of women. She has successfully advocated for women, girls and families at all levels including policy forums and with the Ryan White Planning Council where she made a difference in breaking down many of the barriers women face in accessing services. She has sat on several other committees, including, the PWA Committee, the District of Columbia’s Mayor’s Task Force on AIDS. She was also the co-chair of a committee that looked at Medicaid waivers for DC. Currently she is engaged as a member of the National Center for Behavior Change’s National HIV Prevention Policy Formulation and Education Workgroup and Coalition. She also speaks on Capitol Hill to address issues that women and girls living with HIV/AIDS face in the fight against the disease. Pat has received the National Association of People with AIDS (NAPWA) Certificate of Recognition of efforts on behalf of women living with HIV/AIDS in DC and the National Association for the Advancement of Colored People (NAACP) Youth Council of DC’s Outstanding Leadership Award. She was recognized as a Hero in the Struggle, an honor of the Black AIDS Institute - honorees include Coretta Scott King and Dr. M. Jocelyn Elders. Pat also received the prestigious Gloria Award from the Ms. Foundation for Women.

Jacqueline (Jacqui) Patterson – Jacqui is the Director of the Climate Justice Initiative at the NAACP. Most recently a global women’s rights consultant, Jacqui has enjoyed a rich career working in the capacities of researcher, program manager, coordinator, advocate and activist working on women’s rights, violence against women, HIV&AIDS, racial justice, economic
justice, and climate justice. Since 2007, Jacqui has served as coordinator for Women of Color United, an organization she founded. As WOCU coordinator, Jacqui has recently emerged as a leader in the climate justice movement, currently working on a climate justice road tour to expose issues of environmental racism in communities of color and ensuring that the voices, demands and leadership of women of color are at the forefront of policy making spaces at upcoming UN meetings, the G-20 convening, and in the formulation and advancement of the Waxman Markey Climate Bill. Previously, Jacqui served as a Senior Women’s Rights Policy Analyst for ActionAid, where she ensured the integration of a women’s rights lens for the issues of food rights, macroeconomics, and climate change as well as the intersection of violence against women and HIV&AIDS. Prior to this, Jacqui served as Assistant Vice-President of HIV/AIDS Programs for Interchurch Medical Assistance, Inc. providing management and technical assistance to medical facilities and programs in 23 countries in Africa and the Caribbean. Jacqui served as the Outreach Project Associate for the Center on Budget and Policy Priorities, as policy analyst for Baltimore City Healthy Start, and Research Coordinator for Johns Hopkins University. A returned U.S. Peace Corps volunteer, Jacqui holds a master’s degree in social work from the University of Maryland and a master’s degree in public health from Johns Hopkins University. She currently serves as Public Policy Co-Chair of the National Association of Black Social Workers, the Executive Committee for the Congressional Black Caucus Fellows Alumni Program, The Leadership Circle of the Women’s Working Group of the US Social Forum, Coordinator for Women of Color United, and the Advisory Committee for The Grandmothers’ Project, the Steering Committee of ATHENA Network, as well as serves as a Co-Chair of the Board of Directors of Health GAP (Global Access Project).

Marcus Pope – In July 2005, Marcus was hired by the Minnesota Center against Violence and Abuse (MNCAVA) to work on a collaborative project with the Institute on Domestic Violence in the African American Community (IDVAAC). Today, Marcus is the Associate Director of IDVAAC. One thing he is especially excited to contribute to IDVAAC is his experience building relationships corporations and foundations. Marcus has a background working with foundations, writing foundation grants, and cultivating relationships with different types of donors. Additionally, he is especially interested in bridging gaps between the research institute and people facing domestic violence issues in the community. Prior to starting at IDVAAC, Marcus spent three years working in the University of Minnesota’s School of Social Work. He also worked in the Youth Studies department, as an academic adviser and mentor to undergraduate students. Additionally, Marcus worked in the Twin Cities as a program director for a health care and social service agency called Neighborhood Involvement Program (N.I.P.). N.I.P. offers a community clinic, a rape and sexual abuse center, a counseling center, therapy associates, a seniors program, a youth program, and the academic-based Cargill Scholars program.

Serra Sippel – Serra is the President of the Center for Health and Gender Equity (CHANGE), a Washington, D.C.-based nongovernmental organization that seeks to ensure that U.S. international policies and programs promote sexual and reproductive health and human rights for women and girls worldwide through comprehensive, effective, rights-based approaches to reproductive and sexual health concerns—including family planning, maternal health, HIV and AIDS—and increased funding for critical programs. Serra has more than sixteen years of advocacy experience on women’s rights issues. Prior to joining CHANGE,
she was International Program Director at Catholics for a Free Choice where she worked collaboratively with women’s rights activists around the world to secure and promote women’s rights and sexual and reproductive health globally. In addition to her years at CFFC, Serra has been involved in the fight for women’s rights through her work at a homeless shelter for women with children in Texas and on behalf of incarcerated women in the state of Indiana. Serra holds a master’s degree in religion. She is the author of numerous articles and other publications on sexual and reproductive health and rights, and has spoken at conferences internationally.

**Vickie Smith** – Vickie is the Executive Director at the Illinois Coalition Against Domestic Violence. She began her work in the battered women’s movement over 27 years ago by providing direct services to survivors of domestic violence. She helped open a non-residential crisis intervention program, first serving on the Board of Directors and then serving as the first non-paid director. Vickie joined the staff of the Illinois Coalition Against Domestic Violence in March 1988 as a Grant Monitor, and then became Executive Director in 1993. Vickie has done work in the battered women’s movement on the national level. She is a founding Board member of the National Network to End Domestic Violence, a national advocacy agency located in Washington D.C. During the development of the National Network, Vickie worked with other state and national advocates on drafting the historic 1994 Violence Against Women Act, which has had a significant impact on services for battered women. In May 1999, she relocated to Texas where she joined the National Training Center on Domestic and Sexual Violence and participated in technical assistance and training all over the United States. Vickie resumed the position of Executive Director of ICADV in August 2008.

**Rona Taylor** – Rona is the Organizer for the National Women and AIDS Collective (NWAC) which is a project of the Ms. Foundation for Women. NWAC is committed to women’s social justice by building the collective power and solidarity/sisterhood of HIV positive women. Prior to the Ms. Foundation project, she was the National Technical Assistance Coordinator at the Harm Reduction Coalition where she helped set up syringe exchange programs, run, and expand their services. She also worked at the Harm Reduction Coalition as the Coordinator for the African American Capacity Building Initiative (AACBI). She is the Board President for the Women’s HIV Collaborative of New York and in addition to her work around HIV/AIDS, she is also very involved in human rights, racial and reproductive justice work.

**Cynthia Tucker** – Cynthia has been working in prevention for over seventeen years. As the Director of Prevention and Community Partnerships, Cynthia is responsible for all private funds raised by AFC to be dispersed to the communities through their annual grant cycle process. Formerly, she was the director of prevention at Chicago Women’s AIDS Project (CWAP) for over eight years. There she conceptualized new ways for working with African American communities and created programs that are responsive to the epidemic. She has previously worked for Planned Parenthood, planning and facilitating workshops specifically for young women. Cynthia is a current member and past chair of the City of Chicago, HIV Prevention Planning Group (HPPG), past member of the Illinois Prevention Planning Group (PCPG) and the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) and past board member of the Chicago Women in Philanthropy (CWIP) and chair of the Illinois Women of African Descent (ILWAD). Cynthia is a member of several advisory boards including the
Domestic Violence/HIV/AIDS National advisory group, the Hardship, Health and Renewal (a study about Economic Survival Strategies among Women Living with HIV), Behavioral & Social Science Volunteers (reviews program materials for cultural relevancy and appropriateness) and with the University of Illinois Chicago Project Wish (Vaccine trails). Cynthia has a master’s degree in curriculum and instruction and a bachelor’s degree in nutrition.

Donna (DeeDee) Williams – DeeDee has more than twenty years of experience working in the field of HIV/AIDS. Her other work experience includes 7 years with high-risk women and children affected by substance abuse, early childcare development, program implementation, women’s issues and community activism. She has more than ten years of management level experience and her dedication to direct services at Sojourner House - a domestic violence program in Providence, RI - has earned her a notable reputation in the community. DeeDee is devoted to her community and works tirelessly for women’s issues. As a Licensed Minister, she reaches out to the homeless population and those who are underserved. DeeDee was awarded the John Hope Settlement House Outstanding Women’s Award for community service in March 2007. She has held the position of co-chair for the Community Planning Group for HIV Prevention for 4 years and has recently been selected as a Commissioner for the Human Relations Commission of Providence, RI.
Background

HIV/AIDS

HIV, the Human Immunodeficiency Virus, is the virus that can lead to AIDS (Acquired Immune Deficiency Syndrome). HIV is transmitted through blood, semen, vaginal secretions and breast milk. When we use the term HIV, the person living with HIV can be at any one of these four stages:

- Incubation period
- No Symptoms
- Later Stage of HIV
- AIDS

People living with HIV may be asymptomatic for years after infection. In the US, approximately 25% of all people living with HIV are unaware of their serostatus, and as a result may unknowingly transmit HIV.

AIDS (Acquired Immune Deficiency Syndrome) is used as a description for advanced-stage of HIV disease. AIDS refers to individuals who have particular “AIDS-defining” conditions or by a CD4+ T cell count below 200 cells per cubic millimeter.

While there is still no cure for HIV/AIDS, the disease can be prevented, and the disease can be managed with antiretroviral treatments, prevention, housing, nutrition, supportive services and primary care.

In the United States, the HIV/AIDS epidemic is considered a growing health crisis for women and girls. Though the Center for Disease Control (CDC) estimates that men were 3 out of every 4 AIDS diagnosis and 73% of HIV diagnosis, women constitute an increasing proportion of new HIV/AIDS cases. (CDC, 2006) Based on the CDC’s most recent estimates for the year 2008, close to 10,332 women were diagnosed with HIV infection and 9,577 women were diagnosed with AIDS. Today, women represent a larger share of new HIV infections compared to earlier in the epidemic. The proportion of AIDS diagnosis among women has tripled since 1985. Between 1999 and 2003, AIDS diagnoses increased 15% among women (and increased 1% among men). (CDC, 2003)

There are many factors influencing the transmission and progression of HIV/AIDS. Gender is one crucial factor. Women are 2-5 times more likely to contract HIV from men during sexual intercourse than vice versa. Women are biologically and physiologically more susceptible to HIV infection than men. In addition to the biological and physiological factors affecting women’s risk of HIV infection, violence and the fear of violence increase women’s vulnerability to HIV infection. Violence or the fear of violence limits a woman’s ability to negotiate safe sex practices, thereby increasing her chances of contracting HIV. The presence of violence in a woman’s life may also make it difficult for her to seek HIV antibody testing, disclose results, and access health care or supportive services.

Heterosexual contact is the most common method of contracting HIV among women (74% in 2008), followed by injection drug use (24%). (CDC, 2006) Since the epidemic began, 1/3rd of
AIDS cases had a direct or indirect connection to injection drug use. This means that though women’s risk of contracting HIV is through heterosexual sexual intercourse, sexual behavior may be with an injection drug user.

Additionally, the disease disproportionately affects women of color. (CDC, 2006) African American and Hispanics and Latinos represent 24% of all women in the United States but account for 82% of AIDS cases among women, according to amfAR (National AIDS Research Foundation) a leading group in research into prevention and treatment established in 1983.

DOMESTIC VIOLENCE

The phrase domestic violence, also known as intimate partner violence, includes the acts and behaviors commonly understood as domestic violence and dating violence, and means an act or pattern of acts [involving the use or attempted use of physical, sexual, verbal, emotional, economic, or other forms of abusive behavior] used by a person to harm, threaten, intimidate, harass, coerce, control, isolate, restrain or monitor another person who is:

- A current or former spouse, domestic partner or dating partner of the victim or survivor of domestic violence.
- A person with whom the victim or survivor of domestic violence shares a child in common
- A person who is cohabiting with or has cohabited with the victim or survivor of domestic violence as an intimate partner.
- A person with whom the victim or survivor of domestic violence has or has had a social relationship that involves a physical, sexual, or emotional component, regardless of the length of the relationship, or the number of interactions between the individuals involved.

Domestic violence occurs in same sex relationships at the same rate as heterosexual relationships.

INTERSECTION OF DOMESTIC VIOLENCE AND HIV/AIDS

At the core of domestic violence and HIV/AIDS is sexuality. Sexual violence is a common tactic abusers use to control their partners.

The Centers for Disease Control defines sexual violence as “any sexual act that is forced against someone’s will.” “Sexual violence can be verbal, physical, and psychological and includes a completed or attempted sex act, abusive sexual contact, and non-contact sexual abuse, which can include voyeurism, exposure, pornography, sexual harassment, threats of sexual violence, and other acts.”

“Globally, nearly one in four women may experience sexual violence by an intimate partner in her lifetime.” (Jewkes, Sen, and Garcia-Moreno, p.157, 2002) One in three women worldwide have been beaten, coerced into sex, or otherwise abused by their partner in their lifetime.

A 2004 study by Dunkle et al of 1,366 South African women in health centers, found that women who are beaten or dominated by their partners were 48% more likely to become HIV infected than women in non-violent relationships. In the December 1999 edition of
Population Reports, in a survey of 136 HIV related healthcare providers in the US, 24% of their patients experienced physical violence after disclosing their HIV status and 45% feared such a reaction.

As Peter Piot, executive director of UNAIDS stated in 1999, “Violence against women is not just a cause of the AIDS epidemic, it can also be a consequence of it.” HIV/AIDS and Violence Against Women Panel on Women and Health Speech by Peter Piot, Executive Director (UNAIDS before United Nations on March 3, 1999).

Violence against women is a cause of the AIDS epidemic because of gender based violence in all forms, and specifically because perpetrators of domestic violence use sexual violence to control their intimate partners, thus increasing the risk of contracting HIV, causing an HIV/AIDS epidemic. Domestic violence cannot “cause” HIV infection, but rather there is an increased risk of HIV/AIDS among women who are victims of domestic violence. Being HIV positive is also a significant risk factor for increased violence and control by an abusive partner. Just as women are more vulnerable to interpersonal violence than men, it is likely that they are also more vulnerable to violence following disclosure than men. (Meeting report from WHO – Violence against Women and HIV/AIDS: Setting the Research Agenda, Oct. 2000)

Given these realities, it is paramount that community domestic violence programs and HIV/AIDS programs assess their readiness to address the intersection of domestic violence and HIV/AIDS; develop competency of understanding of the intersection and of the issue that is not their primary service area; enhance skill sets and thus services; build program capacity, including the development of promising practices and policies and procedures; and form collaborative partnerships, exchanging their experiences and expertise and learning from existing initiatives. An understanding of and sensitivity to this intersection by both domestic violence programs and HIV/AIDS programs can affect the physical and emotional safety and well-being of all service participants, whichever provider is the initial point to accessing services.

**LANGUAGE AND TERMINOLOGY**

In the field of domestic violence, there are terms that may be used interchangeably. One is intimate partner violence. Domestic violence or intimate partner violence is about violence in intimate relationships. An intimate relationship is defined as current spouse, ex-spouse, significant other or partner or ex-significant other, person who cohabitates or has cohabitated in an intimate partner relationship, domestic partner, boyfriend/girlfriend, adults related through blood or marriage, individuals who are dating or have dated (irrelevant of the amount of time spent dating, and a person with whom a child is shared in common) and refers to heterosexual and same sex relationships. Domestic violence occurs in same sex relationships at the same rate as heterosexual relationships. Dating violence includes not just adults but also minors. If the individual or individuals define their relationship as intimate—whether or not there has been a physical or sexual relationship – then it is such.

Victim of domestic violence is another term for which there are other word choices. Victims may prefer the term survivor of domestic violence or victim/survivor.

Those who commit domestic violence are called batterers or abusers. The only difference between these terms is that batterer means the person has physically or sexually hurt the
other person while abuser means all forms of violence including physical and sexual. Again these terms are often used interchangeably.

In 2010 the CDC began to use the following language for any person who is infected with HIV, no matter the stage of disease progression: “diagnosis of HIV infection” and “person living with a diagnosis of HIV infection.” Once the person is diagnosed with AIDS, that individual is called a person living with AIDS. Going by CDC’s language recommendation and recognizing that HIV is the virus that leads to AIDS, we will use the term HIV/AIDS throughout this curriculum when talking about individuals living with HIV/AIDS, unless we are talking about HIV or AIDS-specific information.

With regard to transmission of HIV, we will use terminology that addresses high risk behaviors that may lead to HIV exposure and infection. We will avoid the terminology of “risky” sex or behaviors which is subjective to those engaging in sexual activities (what may be considered “risky” sex to some may not be “risky” to others).

Additionally, there are words common to the HIV/AIDS and domestic violence fields. In the HIV/AIDS field, client is a term that is often used for a person diagnosed with HIV or living with AIDS, especially in a medical setting. The same term in the domestic violence field may apply to a survivor who is staying at a domestic violence shelter or who is receiving individual psychological or group psycho-educational services from a domestic violence program. More often, however, domestic violence advocates refer to persons in or leaving a domestic violence relationship as service participants or service recipients.

Those who work in the domestic violence field are usually called domestic violence advocates or counselor/advocates. In the HIV/AIDS field, they are called HIV/AIDS service providers or advocate. An HIV/AIDS service provider can be an individual living with HIV/AIDS who advocates on behalf of other individuals living with HIV/AIDS.

It is important to try and use language that is gender neutral. However, 85% of abusers are male with female victims. There are female abusers with male victims and domestic violence exists in both male and female same sex relationships. Trainers should explain that they may be using he/him for abusers and she/her for survivors, but the trainers should occasionally “switch” terms. The same applies to HIV/AIDS. Not all sex workers are female though they may be the majority.

NOTE: Each trainer needs to use the terms for which she/he and/or the audience has the greatest comfort. The trainer should inform the group which term will be used primarily throughout the training and ask if the term resonates with the audience. Trainers may interchange terms and should inform participants that they will interchange terms throughout the training. For more information, there are basic DV and HIV/AIDS glossaries included in the resources section.

COMPETENCIES

Domestic violence advocates and HIV/AIDS service providers conducting this training are the experts in their respective fields. The curriculum provides the information necessary to understand the intersection of these two fields. However, since the core of the intersection is
sexual violence in the context of domestic violence, it is important to include sexual violence advocates in this training.

Both trainers need to realize that there are multiple intersections when dealing with the intersection of domestic violence and HIV/AIDS such as mental health, substance abuse, trafficking, sex workers, teens, poverty and disabilities. These factors impact the different way individuals access, participate and respond to services. However, this is an introductory workshop on the intersection of domestic violence and HIV/AIDS and there is insufficient time to address all these factors in this training. Trainers should remind their audience that individuals seeking their services will have had various experiences and that will make each case unique and all service providers should be sensitive to these issues in their work.

While domestic violence and HIV/AIDS affect all races or ethnicities, Communities of Color are disproportionally affected by both. Communities of Color often face economic barriers, language access and acculturation issues, challenges dealing with the criminal justice system, racism, anti-immigrant sentiment, and barriers to accessing health care, among others. These issues have a disproportionate impact on marginalized racial and ethnic communities and result in additional layers of complexity in reaching and providing assistance to these victims. Too often, historically marginalized racial and ethnic communities have lacked adequate access to effective services. The complexities of addressing violence against women within Communities of Color are vast and cannot be addressed by merely translating brochures or using a “one-size-fits-all” approach. Partnerships and collaborations with community-based organizations addressing the issues of domestic violence and/or HIV/AIDS in Communities of Color in culturally and linguistically specific ways are important in dealing with the intersection of domestic violence and HIV/AIDS.

Trainers should be sensitive to the stigma, shame, and isolation that are often reflected in the lives of survivors of domestic violence and persons living with HIV/AIDS or persons who live with both in their lives. There may be survivors of domestic violence or persons living with HIV/AIDS in the participant group.

Trainers must be skilled in handling the issues that may arise during the training. These could include resistance to taking on “more work,” issues around sex workers or trafficking and HIV transmission, survivors of domestic violence and their decisions around staying or leaving an abuser. These issues can elicit much discussion, so trainers must be able to effectively deal with discussions and remain mindful of the purpose and focus of the training and time frames of the agenda.

Sexuality is at the core of intersection of domestic violence and HIV/AIDS, so it is important that both trainers are more than comfortable discussing sex and sexuality—terminology, behaviors, beliefs.

Trainers need to be mindful that while there is a connection between domestic violence and HIV/AIDS, it does not mean that every survivor of domestic violence has HIV/AIDS or that every person diagnosed with HIV/AIDS is a survivor of domestic violence. The intersection is a risk not a reality for each individual. Participants should leave the training with this message.
TRAINING OVERVIEW

TRAINING PURPOSE
The main purposes of this training are to:

- Increase the knowledge, understanding, and competencies of domestic violence advocates and HIV/AIDS counselors in addressing the intersection of domestic violence and HIV/AIDS with service participants
- Build collaborative partnerships between our organizations to improve service delivery and increase the safety of the people requesting our services

By increasing knowledge, understanding, and competencies around these issues and adopting promising practices in both fields, building collaborative partnerships and promoting organization shift to a new way of thinking about advocacy and service-delivery we hope to improve the overall safety of both domestic violence survivors and individuals living with HIV/AIDS.

LEARNING OBJECTIVES
Participants will be able to:

- Build an understanding of the intersection between domestic violence and HIV/AIDS
- Gain an understanding of domestic violence as a pattern of power and control tactics of batterers/abusers
- Increase knowledge of HIV transmission, disease progression, prevention, and risk reduction
- Understand how beliefs and attitudes about domestic violence and/or HIV/AIDS influence service provision
- Increase skill and competency in the development of promising practices that enhance safety for individual survivors of domestic violence and HIV/AIDS
- Specify advocacy and collaborative strategies for partnerships between community domestic violence programs and HIV/AIDS programs
- Highlight the impact of disparities - race, culture, socio-economic factors, geography, gender, sexual identity, disabilities, citizenship/legal status, occupation - on the lives of survivors of domestic violence and/or persons living with a diagnosis of HIV/AIDS

LENGTH OF TRAINING
8 Hours (7 hours with two 15 minute breaks, one 10 minute break and one 45 minute lunch)

SUGGESTED MATERIALS

- Name tents
- Markers
- Poster paper
- Screen, computer, LCD projector, disc or flash drive with PowerPoint presentation (2 of each for the 2 concurrent breakouts)
- 2 easels for poster board tablets
- Handouts of the PowerPoint presentation
- Handouts of exercises and resources

TARGET AUDIENCE

The primary audience is domestic/sexual violence advocates and HIV/AIDS service providers together; however, any provider of human services that works with clients that are survivors of domestic violence and/or persons living with a HIV/AIDS would benefit from an understanding of the intersection. This curriculum could also be utilized by a domestic violence program to provide training to an audience of only HIV/AIDS service providers or by an HIV/AIDS program for domestic violence or sexual violence advocates. Audience members can and should include victims and survivors of domestic violence and persons living with HIV/AIDS or at risk for HIV infection.

The audience should expect this training to be a basic or introductory training to domestic violence, HIV/AIDS and the intersection of the two issues. For more advanced topics on either issue or the intersection, the audience can contact the trainers in their state and/or the National Network to End Domestic Violence (NNEDV) (the technical assistance provider who developed this curriculum) to make their interests known. If there is enough interest, the trainers and/or NNEDV can coordinate a future training to address advance topical training and technical assistance needs.

CURRICULUM OUTLINE

The Intersection of Domestic Violence and HIV/AIDS curriculum is divided into 7 sections:

1. Introduction - participants will understand the purpose, learning objectives and expectations of the training
2. Beliefs and Attitudes –participants will understand how beliefs and attitudes influence service provision and participants will examine their personal comfort levels when providing services to survivors of domestic violence or persons living with HIV/AIDS
3. Understanding Domestic Violence – participants will gain knowledge of domestic violence and build an understanding of the life generated risks that impact the decision making of survivors of domestic violence
4. Understanding HIV/AIDS – participants will increase knowledge of HIV/AIDS and begin to build an understanding of the intersection with domestic violence
5. The Intersection of DV & HIV/AIDS – participants will build an understanding of the intersection between domestic violence and HIV/AIDS
6. Promising Practices – participants will develop increased skill and competency to better serve survivors of domestic violence living with HIV or at risk for HIV infection and participants will initiate promising practices for service provision

7. Collaboration – participants will identify and understand the benefits of collaboration as well as the best methods for developing partnerships

Each section of the curriculum contains a trainer notes and a training section. The trainer notes section includes useful information for the trainers including: length of time, methods of presentation, materials needed, learning objectives and outline of presentation. The training section includes steps for presenting as well as the PowerPoint and exercises referenced during the section. There will be training notes incorporated throughout the curriculum to guide trainers through the curriculum or refer trainers to available resources.

**TRAINER EXPECTATIONS**

The curriculum is detailed, thorough and user friendly. Trainers in both fields will be more than able to utilize the curriculum to conduct the training by becoming familiar with the content and then preparing, practicing and personalizing the curriculum. This is an introductory workshop. It is expected that the participants, representing community programs, will see the need to provide and participate in further more intensive cross training opportunities.

This training would be most effective if a domestic violence advocate and HIV/AIDS service provider co-train. The workshop demands that the trainers have a good working relationship before the training and allow adequate planning time together to be a smooth functioning training team. The co-trainers will need to collaborate on who will be the lead trainer for various sections. Each trainer brings a wealth of knowledge, expertise and experiences to the presentation and trainers should, as appropriate, make this training “their own,” while following the curriculum content, activities and time frames.

This curriculum was developed to be used by domestic violence advocates and HIV/AIDS counselors in all parts of the country; however state laws in both these fields vary widely. The trainers must be knowledgeable about their state confidentiality laws regarding domestic violence and HIV/AIDS, including address confidentiality; anonymity and other requirements or regulations for HIV antibody testing, including partner notification of test results; and child abuse laws or practices in families in which there is domestic violence. An understanding of state laws greatly impacts safety planning and risk reduction as well as documentation in client files. Trainers should share their respective information and understanding of their state’s legal mandates. It may also be helpful to have copies of relevant laws at the training and any web sites participants could access for state laws. The American Bar Association website has a compendium of all state confidentiality laws for domestic violence and sexual assault.

To make the training more engaging and demonstrative of the ways domestic violence and HIV/AIDS affects lives, trainers must be able to weave in their own experiences as trainers or service providers and survivor stories. It is imperative to have written permission to share a particular individual’s “story”; otherwise, trainers should use anonymous stories. The
trainers can and should incorporate videos or other media presentations as applicable in any step of the curriculum, being mindful to accomplish the purpose and time frame of that step.

This curriculum is written so that the participants are divided into 2 groups for a portion of the training. The purpose of the separate groups is to educate the HIV/AIDS service providers on domestic violence and domestic violence advocates on HIV/AIDS without the respective groups having to sit through training on an issue they already understand. The trainer most knowledgeable in domestic violence will conduct that portion of the training (Section 3) for those in the HIV/AIDS field. The HIV/AIDS trainer will conduct that portion of the training (Section 4) for domestic violence advocates. Each trainer should make their specific section of the training “real” by incorporating personal stories, while maintaining confidentiality, and professional experiences that will enrich the information. Short videos can be utilized as well.

It is recommended that advance registration be done rather than have the training just be open. As part of the registration ask for an e-mail address and ask if the participant agrees that their name, program, and e-mail address can be shared with the other workshop participants. Give an opt-out option. As part of the registration, ask for information about the participant’s program services. Compile the contact and services information as a handout to be distributed at the conclusion of the training. This will enhance continued collaboration between participants after they leave the training. The registration form should also include a question about the participants’ current knowledge of domestic violence and/or HIV/AIDS. If the majority of the participants already have a basic understanding of the issues, trainers will know ahead of time that they can spend more time discussing the issues in greater detail rather than just covering the basic information. When making arrangements for the site of the training, it is important to have a room large enough for participants to move freely and work in groups without distracting other groups and sufficient wall space to hang poster paper. Additionally, there needs to be a separate smaller breakout room so participants can be separated into 2 groups.

It is recommended that participants sit at tables with 5-6 participants at each table. Be creative in ensuring that both domestic violence advocates and HIV/AIDS providers are sharing a table together. One way to do this is to review the registration list which would show the program affiliation. Go through the list and pick 5-6 people who do not work together. Place the same color dot on their name tags and upon arrival at the training, ask them to sit at a table with that color dot on a card at a table. Select another group and place a different color dot on their name tags and tables. Repeat this for the entire list of participants.

If tables are not available, move chairs into small circles. Moving into small circles for discussion also helps to facilitate group work. For small group work, if the total number of participants is too few, ask participants to move temporarily so there are 3-4 in a group. If you have a larger group, more than one small group could be doing the same tasks as another group.

If possible, the trainers should have someone who can handle the registration the day of the training, so trainers can focus on being ready for the training. This also allows trainers to walk around, greet participants as they get settled and generally begin to create a welcoming safe training environment.
As with any curriculum, each trainer is encouraged to make this training their own and adapt it to suit their audiences’ needs.

TRAINER NOTES:

Here is the key for different text styles and colors used throughout the training:

- **TEXT in BOLD and ITALICS** = suggested language for the trainers to use during the presentation
- **PURPLE AND BOLD TEXT** = steps and breaks in the training
- **Text in Grey** = Trainer Tips to assist with presenting and keeping your training on track