SEXUAL VIOLENCE AND HIV

A Technical Assistance Guide for Victim Service Providers

NSVRC
national sexual violence resource center

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The link between sexual violence and HIV

Sexual violence and the Human Immunodeficiency Virus (HIV) are two serious and often interconnected global public health problems that spare no region of the world, race, ethnicity, gender, class, sexual orientation, age, religion, or ability/disability. Sexual violence increases a victim's risk of contracting sexually transmitted infections, including HIV. The short- and long-term effects of sexual violence and HIV can be both physically and psychologically debilitating for victims. The social stigma that surrounds both issues can be severely isolating and burdensome, often preventing victims from disclosing and receiving the services they need. For people of color; lesbian, gay, bisexual, and transgender (LGBT) individuals; sex industry workers; people living in poverty; people with disabilities; victims of sex trafficking; and victims of marital or intimate partner rape; the barriers may be even greater due to discrimination, isolation, and a lack of culturally sensitive services.

Both sexual violence and HIV have origins in oppression. Common risk factors for both sexual violence and HIV/AIDS include gender-based inequality; male entitlement and patriarchy; absent or weak sanctions, services, and responses; social instability; and poverty (Jewkes, Sen, Garcia, 2002; UNAIDS, 2004).

Women, people of color, youth, and residents of developing and poor areas are disproportionately affected by HIV/AIDS due largely to gender, racial, social, and economic inequities that ravage our society and world (UNAIDS, 2004). This guide provides information on the prevalence of sexual violence and HIV, types of available HIV testing and treatment, benefits and risks of such testing and treatment, victims' possible fears surrounding HIV, sexual offender testing, and steps victim service professionals can take to meet the needs of sexual violence victims.

Definition of Sexual Violence

"Sexual violence is any sexual act that is forced against someone's will" (CDC, 2006j). "Sexual violence can be verbal, physical, and psychological and include 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." (CDC, 2006j).

Prevalence of Sexual Violence

Because sexual violence is greatly underreported and existing studies are limited, prevalence statistics vary. However, based on existing research, sexual violence affects millions of people each year globally. Globally, twenty percent of women report a history of child sexual abuse (Runyan, et al., 2002). In the United States, one in four girls and one in six boys will be sexually assaulted by their eighteenth birthday (Finkelhor et al., 1990). 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).

Definition of HIV

HIV is a viral infection that may be passed through sexual contact with an infected person, and/or by sharing needles and/or syringes (primarily for drug injection) with someone who is infected (CDC, 2007). A woman with HIV can pass the virus to her baby during pregnancy, delivery, and through breastfeeding (CDC, 2007). HIV is spread through the following body fluids: blood, semen, vaginal secretions, and breast milk (CDC, 2007). Some people with HIV infection develop Acquired Immunodeficiency Syndrome (AIDS). AIDS is the weakening of an individual's immune system due to the depletion of white blood cells (NIH, 2005). Cell depletion undermines an individual's ability to stave off infections and diseases that can become life-threatening infections and cancers (NIH, 2005). While there are treatments available, currently, there is no vaccine or cure for HIV/AIDS (NIH, 2005).

Prevalence of HIV/AIDS in the United States

According to the Centers for Disease Control and Prevention (CDC), there were approximately 1,039,000 to 1,185,000 persons in the United States living with HIV/AIDS in 2003 (CDC, 2006a). According to 2005 CDC surveillance data, 40 to 44 year olds comprise the largest age group of persons living with HIV/AIDS (CDC, 2005). The majority (47%) of persons living with HIV/AIDS are black; 34% are white; 17% are Hispanic; and less than 1% each are American Indian/Alaska Native and Asian/Pacific Islander (CDC, 2005).

Seventy-three percent of persons living with HIV/AIDS are male (CDC, 2005). Males contract the disease in the following ways, which are ranked from most to least common: sex with men (61%), intravenous drug use (18%), sex with women (13%), and sex with men combined with intravenous drug use (7%) (CDC, 2005). Thirty-seven percent of persons living with HIV/AIDS are female (CDC, 2005). Seventy-two percent were exposed through heterosexual contact and 26% through injection drug use (CDC, 2005).

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(CDC, 2005)

HIV/AIDS among sex industry workers and victims of sex trafficking

While it is difficult to measure and document the impact of HIV/AIDS on sex industry workers and victims of sex trafficking, existing research suggests that these populations often endure high levels of sexual violence. They also often lack the ability to protect themselves from sexually transmitted infections and HIV due to power imbalances with their customers and lack of access to contraception.

In a study of 50 incarcerated women in the Boston area serving time for prostitution-related offenses, physical and sexual violence were found to be common occurrences (Norton-Hawk, 2002).

Forty-six percent reported physical abuse and 42 percent reported sexual abuse (Norton-Hawk, 2002). Given the physical and sexual violence that sex industry workers suffer at the hands of their pimps and customers and the high rates of intravenous drug use (56 percent reported they used drugs intravenously), they are at great risk for HIV (Norton-Hawk, 2002).

Seventy percent of the women said they were very concerned about contracting sexually transmitted infections, including HIV (Norton-Hawk, 2002). Sex industry workers often have little or no opportunity to protect themselves from HIV and other sexually transmitted infections. In the Boston study, 16 percent of the women reported being HIV positive and 48 percent reported they are tested every six months (Norton-Hawk, 2002).

Victims of sex trafficking suffer high rates of physical and sexual violence on a daily basis and are therefore at high-risk for contracting HIV and other sexually transmitted infections.

HIV/AIDS among men who have sex with men (MSM)

HIV disproportionately affects men who have sex with men (MSM) in the United States. According to the CDC, two thirds of all HIV infections were among MSM in 2003, although it is important to note that only five to seven percent of men in the United States identify themselves as MSM (CDC, 2006d). While HIV diagnoses decreased in the 1980s and 1990s among MSM, research shows they are currently on the rise again (CDC, 2006d).

HIV/AIDS among women who have sex with women (WSW)

Research on HIV transmission among women who have sex with women (WSW) is quite limited. Although seemingly rare, HIV transmission between WSW can still occur through vaginal and cervical secretions and menstrual blood (CDC, 2006f). Additionally, WSW are at greater risk for contracting HIV if they also inject drugs, have sex with bisexual men, have sex with bisexual men who inject drugs, or engage in anal intercourse (Council on Scientific Affairs, 1996).

HIV/AIDS among women and girls

In the United States, the HIV/AIDS epidemic is considered a growing health crisis for women and girls. Between 1999 and 2003, AIDS diagnoses increased 15% among women (and increased 1% among men) (CDC, 2003). Women constitute an increasing proportion of new HIV/AIDS cases (CDC, 2006e). Fifty percent of HIV cases in 2003 were among teenage girls between 13 and 19 years of age (Henry Kaiser Family Foundation, 2006). Heterosexual contact is the most common method of contracting HIV among women, followed by injection drug use (CDC, 2006e).

The disease disproportionately affects women of color (CDC, 2006e). In 2002, HIV infection was the leading cause of death among 25–34 year old African American women (CDC, 2006e)In 2004, African American women accounted for 67% of estimated AIDS cases among women, yet represent only 13% of the US population (Henry Kaiser Family Foundation, 2006).

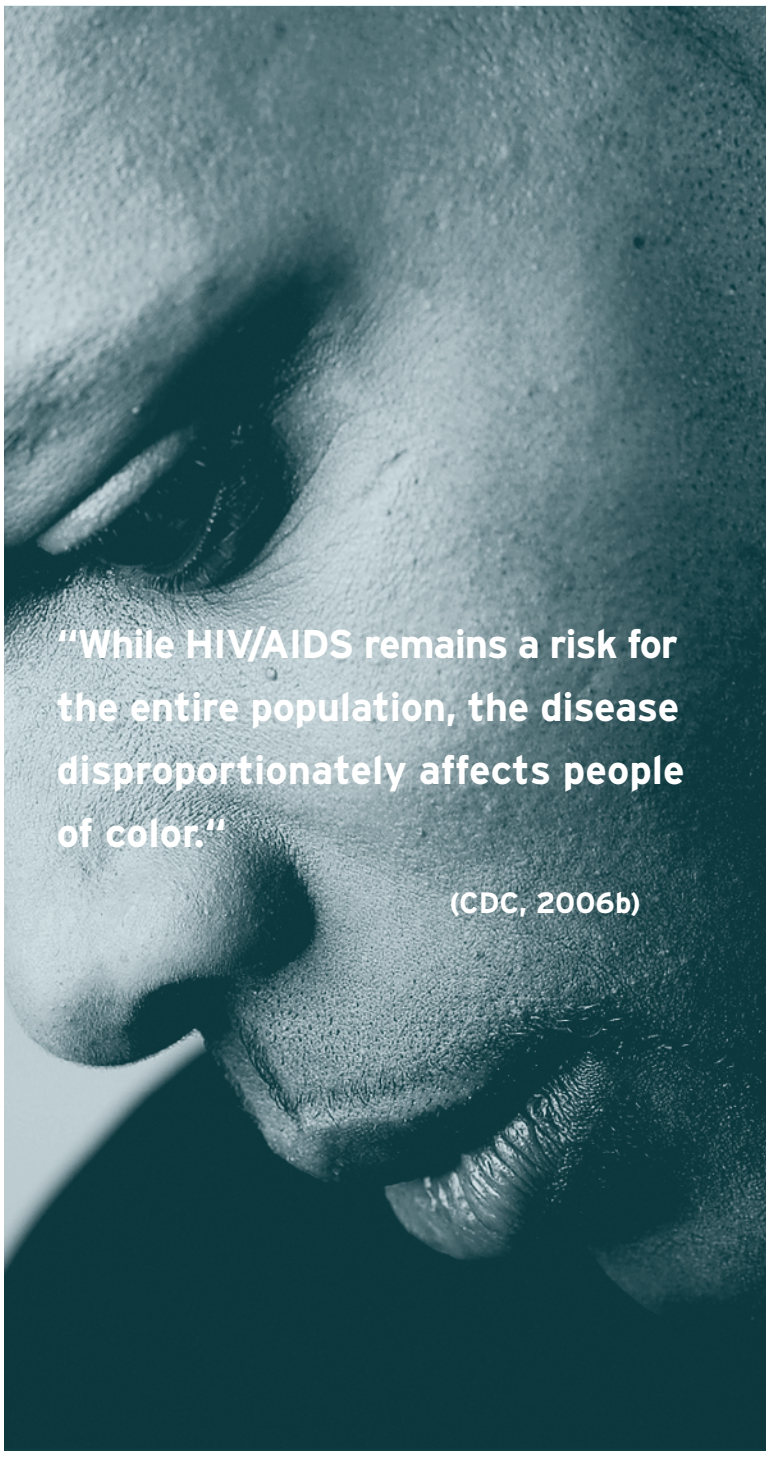
"In 2002, HIV infection was the leading cause of death among 25–34 year old African American women."

(CDC, 2006e)

HIV/AIDS among people of color in the United States

While HIV/AIDS remains a risk for the entire population, the disease disproportionately affects people of color. When compared with all racial/ethnic groups, the African American population experiences the highest rate of AIDS diagnoses in the United States (CDC, 2006b). African Americans comprise 12.3 percent of the U.S. population yet represent 50 percent of all new HIV/AIDS diagnoses (CDC, 2006b). As of 2002, HIV/AIDS was among the top three causes of death for 25 to 54 year old African American men, the top four for 25 to 54 year old African American women, and the number one cause of death for 25 to 34 year old African American women (CDC, 2006b).

The Hispanic population experiences the second highest rate of AIDS diagnoses in the United States among racial and ethnic groups (CDC, 2006c). Hispanics make up roughly 14 percent of the US population, yet represent 18 percent of AIDS cases since the epidemic's onset (CDC, 2006c). Hispanics account for 20 percent of new AIDS diagnoses in the United States today (CDC, 2006c).



Prevalence of HIV/AIDS across the globe

Males comprise the majority of persons living with HIV/AIDS worldwide. However, women and girls are increasingly at risk across the globe. The number of females living with HIV/AIDS significantly increased from 16.5 million in 2003 to 17.5 million in 2005 (UNAIDS & WHO, 2005). "It is often women with little or no income who are most at risk. Widespread inequalities including political, social, cultural and human security factors also exacerbate the [HIV/AIDS] situation for women and girls" (UNAIDS & WHO, 2005).

Worldwide, women and girls are exposed to HIV/AIDS primarily through heterosexual sexual contact (UNAIDS, 2004). "Evidence suggests that sexual and other forms of abuse against women and girls—whether at the hands of intimate partners or strangers—increase their chances of becoming infected with HIV" (UNAIDS & WHO, 2005). The world-over, women and girls often lack control over their own sexuality and reproductive health and therefore, quite frequently are unable to protect themselves from HIV/AIDS (World Health Organization, 2000). Their sexual partners are often much older than them and have already contracted HIV/AIDS, thus increasing their risk of contracting the disease.

Women and girls are often blocked from information about and access to HIV/AIDS prevention and reproductive health options such as condoms. Even when they have access to condoms, women and girls are often unable to negotiate condom use with their male partners due to power imbalances and sexual violence within patriarchal societies.

Global snapshot of HIV/AIDS

- In 2005, forty million persons were living with HIV/AIDS worldwide (UNAIDS & WHO, 2005).
- Fifty percent were men, 45% were women, and 5% were children (UNAIDS & WHO, 2005).
- There were five million new cases of HIV in 2005 (UN AIDS & WHO, 2005).
- Of the 3.1 million AIDS-related deaths, 570,000 were children (UNAIDS & WHO, 2005).
- All regions but the Caribbean saw an increase in the number of persons living with HIV/AIDS from 2003 to 2005 (UNAIDS & WHO, 2005).
- Even though it saw no increase, the Caribbean remains second only to Sub-Saharan Africa in HIV/AIDS prevalence (UNAIDS & WHO, 2005).

Risk factors for contracting HIV through rape

Risk factors for HIV/AIDS occur on individual, family, community, and societal levels. Risk factors include poverty, social instability, family disruption, transmission of other sexually transmitted infections, women's low social and political status, sexual violence, lack of commitment to preventing sexual violence and HIV among leadership, high mobility of persons, especially due to migratory labor (UNAIDS, 2004). According to the CDC, the following individual level risk factors undermine prevention of HIV/AIDS among women of color: young age, lack of recognition of partner's risk, sexual inequality in relationships with men, women's biologic vulnerability to HIV through vaginal intercourse, sexually transmitted diseases, substance abuse, and low socioeconomic status (NASTAD, 2006).

Like other sexually transmitted infections, evidence shows that HIV may be transmitted during a sexual assault. However, contracting HIV through sexual assault is thought to occur infrequently (CDC, 2006h). The CDC estimates the likelihood of contracting HIV from a known positive person through consensual vaginal intercourse at 0.1%–0.2% and through consensual receptive rectal intercourse at 0.5%–3% (CDC, 2006h). It is possible that the threat of HIV transmission is greater in nonconsensual intercourse, or sexual assault, due to potential injuries sustained by the victim. This is especially true for child victims who may suffer repeated abuse and more severe genital and rectal injuries (CDC, 2006h).

These factors may increase the risk of HIV transmission from a sexual assault when the offender(s) is/are HIV positive (CDC, 2005):

- Bite injuries
- Multiple offenders
- Vaginal and anal penetration
- Genital trauma and/or vaginal or anal tears
- The presence of sperm or semen in/around the vagina or anus
- Offender(s) that are injection drug user(s)

HIV testing

Effective HIV testing requires a series of blood tests over a period of time. Currently, the CDC recommends that all persons seeking care following nonoccupational exposure to HIV be tested at baseline, four to six weeks, three months, and six months (CDC, 2005). Additionally, the CDC recommends (CDC, 2006g):

- **HIV screening for patients in all health-care settings—including pregnant women—after the patient is notified that testing will be performed unless the patient declines (opt-out screening).**
- **Persons at high risk for HIV infection should be screened for HIV at least annually.**
- **Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.**
- **Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health-care settings.**

The CDC recommends that sexual assault victims/survivors be tested for HIV at the time of the initial examination and at six weeks, three months, and six months "after the assault if initial test results were negative and infection in the assailant could not be ruled out" (CDC, 2006i). Furthermore, the CDC recommends that healthcare providers discuss the benefits and limitations of antiretroviral prophylaxis options with victims/survivors and if warranted, provide victims/survivors with a 3-7 day supply and schedule a follow-up for additional counseling (CDC, 2006i). The CDC also recommends that testing decisions be made on an individual basis and that experienced clinicians conduct examinations that minimize further trauma to victims/survivors (CDC, 2006i).

What is an HIV antibody test?

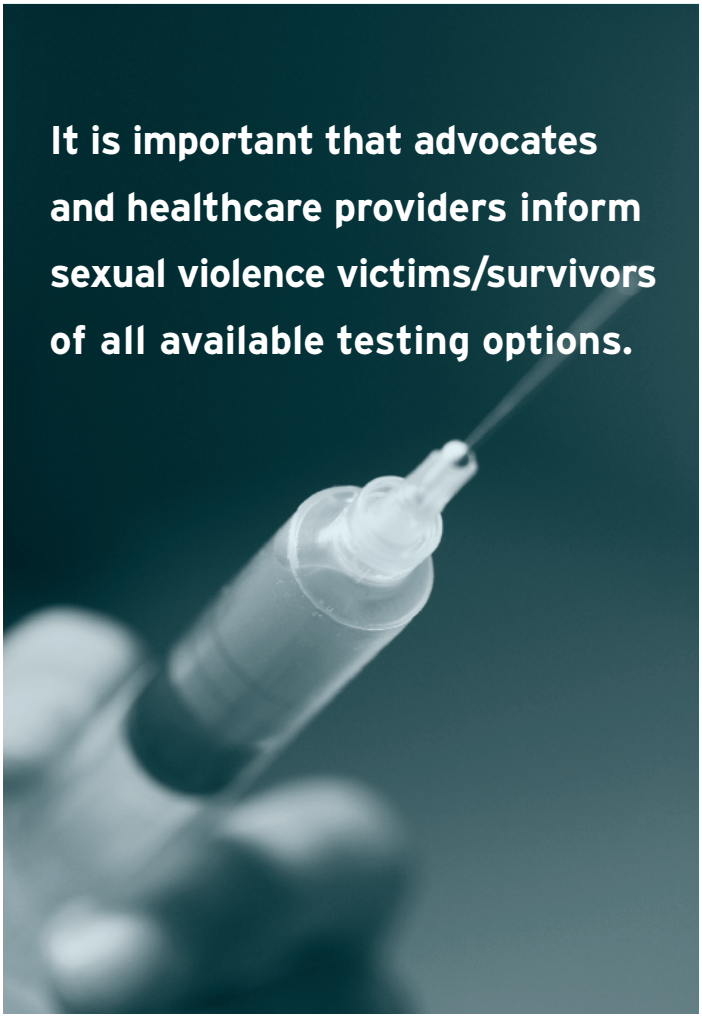
According to National HIV Testing Resources, a service of the CDC; *When HIV enters the body, it begins to attack certain white blood cells called T4 lymphocyte cells (helper cells). Your doctor may also call them CD4 cells. The immune system then produces antibodies to fight off the infection. Although these antibodies are ineffective in destroying HIV, their presence is used to confirm HIV infection. Therefore, the presence of antibodies to HIV result from HIV infection. HIV tests look for the presence of HIV antibodies; they do not test for the virus itself.* (National HIV Testing Resources, 2006).

The enzyme immune assay (EIA) and enzyme-linked immunosorbent assay (ELISA) tests are commonly administered to detect HIV antibodies at initial screening (National HIV Testing Resources, 2006). If initial EIA/ELISA results indicate a reaction, the same blood sample is retested (National HIV Testing Resources, 2006). If the second round of EIA/ELISA testing indicates a reaction, results are "confirmed" using a Western Blottest (National HIV Testing Resources, 2006). The Western Blot is a more rigorous and precise test that can distinguish between HIV-specific antibodies and other antibodies that could cause a false positive result (National HIV Testing Resources, 2006). A person is considered "HIV-positive" if both EIA/ELISA and Western Blot tests indicate that HIV antibodies are present (National HIV Testing Resources, 2006).

How soon can a person get tested?

Antibodies are typically detectable within three months after HIV infection and on average, within 20 days (National HIV Testing Resources, 2006). In rare cases, it can take six to 12 months (National HIV Testing Resources, 2006).

It is important that advocates and healthcare providers inform sexual violence victims/survivors of all available testing options.



Types of HIV testing

There are several types of HIV antibody testing available, including anonymous, confidential, home, and rapid testing. It is important that advocates and healthcare providers inform sexual violence victims/survivors of all available testing options. Additionally, it is critical that advocates collaborate with health care providers to ensure that victims receive support, counseling, and educational resources before, during, and after the testing process. For more information about types and locations of HIV antibody tests, contact your state health departments, the National HIV Testing Resources (www.hivtest.org), or CDC-INFO, a 24-hour hotline that is available 365 days a year to provide information and resources on HIV (1-800-CDC-INFO; TTY: 1-888-232-6348).

Anonymous HIV Testing Anonymous HIV antibody testing services do not require individuals to provide their names when tested (National HIV Testing Resource, 2006). Therefore, when tested anonymously, the person is in ultimate control of the results and determines whether to share them with anyone else such as medical professionals, state health departments, previous and current partners, family/friends, etc.

Confidential HIV Testing Confidential HIV antibody testing services are available to individuals who wish to have some level of privacy. However, it is important to note that results are linked to the individual's name and may be shared with medical personnel and in some cases, state health departments. Test results may still become part of the individual's medical record.

Home HIV Testing Currently, the Federal Drug Administration has approved only one home testing kit, Home Access, which is available in most drug stores (National HIV Testing Resource, 2006). Other home testing kits—which enable individuals to read their own test results in minutes—may produce inaccurate results (National HIV Testing Resource, 2006). Home Access requires individuals to prick their fingers, place blood droplets on a card, and mail the card to a licensed laboratory for testing (National HIV Testing Resource, 2006). Individuals are given an identification number to use when calling in for results. Counseling is available to Home Access consumers throughout the testing process.

Rapid HIV Testing A rapid HIV test can produce results within 20 minutes as opposed to other HIV tests, which can take one to two weeks (National HIV Testing Resource, 2006). Rapid HIV tests are thought to be as accurate as other HIV tests. There are currently four rapid HIV tests licensed and available in the US, although access may differ from community to community (National HIV Testing Resource, 2006).

Prophylaxis treatment

One type of HIV prophylaxis treatment is nPEP, which stands for nonoccupatinoal postexposure prophylaxis treatment. It is a 28-day course of highly active antiretroviral therapy (HAART) that attempts to prevent the contraction of HIV after possible exposure. The CDC recommends nPEP for *"persons seeking care within 72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV infected, when that exposure represents a substantial risk for transmission" (CDC, 2005).*

Treatment typically consists of a combination of two to three antiviral medications prescribed and administered as soon as possible following an HIV-exposure to prevent infection. There are different treatment options available to individuals who test HIV positive (for more information, contact the CDC).

CDC makes no recommendations either for or against nPEP for persons seeking care within 72 hours after possible exposure to a person with unknown HIV status, when "such exposure would represent a substantial risk for transmission" (CDC, 2005). In these cases, clinicians are encouraged to evaluate the risks and benefits of testing and treatment with patients on an individual basis. CDC does not recommend nPEP for individuals who seek care beyond the 72-hour window of exposure or for those who are frequently exposed to HIV infection on a recurring basis through their own behaviors, such as intravenous drug users who share needles or individuals who have unprotected sex with known infected partners.

Benefits of testing and prophylaxis treatment for sexual violence victims

HIV testing is a necessary step in the treatment and prevention of HIV infection. Some research involving animal, human, and laboratory studies suggests that nPEP may be effective in preventing HIV infection after nonoccupational exposure. The sooner an individual starts nPEP—within the 72-hour window discussed earlier—the greater his/her chances are at fighting off HIV infection.

Victims of sexual violence may want to consider immediate HIV testing and treatment; however, positive results at this stage will only indicate that they had contracted HIV prior to the assault. There are anonymous and confidential testing sites available throughout the nation; healthcare providers and advocates should inform victims of these resources (for more information on anonymous and confidential testing see **Types of HIV testing**) in this guide.

Potential concerns regarding testing and prophylaxis treatment for sexual violence victims

For some victims, testing for HIV at the time of the forensic rape exam may exacerbate the trauma of the assault. The possibility that the victim has contracted HIV in addition to having survived rape could be more than she/he can bear or process at that moment. Therefore, it is imperative that victims receive proper counseling, information, and support when considering HIV testing. Because testing detects HIV antibodies that can take up to three weeks to develop, testing for HIV at the time of the forensic exam will only determine if the victim already had the HIV virus prior to the sexual assault.

Some victims may choose to delay the HIV test 24 to 48 hours, which allows them time to weigh their options and make a fully informed decision. Ultimately, the only "right" decisions with regards to testing and treatment are those that victims choose for themselves, after receiving all available information.

For some victims, testing for HIV at the time of the forensic rape exam may exacerbate the trauma of the assault.

Reasons why a victim/survivor may wish to delay or refuse HIV testing:

- Testing in the immediate aftermath of a rape could exacerbate the victim's trauma.
- Adequate HIV test counseling and referrals might not be available to victims in emergency departments throughout the nation. Therefore, victims may not receive the thorough information and support needed to provide informed consent.
- Rape victims who are also victims of domestic violence or sex trafficking may not disclose their risk of HIV or wish to get tested because they may fear retribution from their abusers. Undocumented immigrants may not disclose out of fear of deportation and/or mistrust of social systems.
- Culturally competent testing and counseling services may be lacking, thus creating barriers for some rape victims from disclosing their risk and accessing testing and services.
- Unless getting tested anonymously, HIV tests are not 100% confidential. Positive results follow a victim long-term. Results are often shared among medical personnel. Test results may be reported as part of a mandate to health departments, with the victim's identifying information. Test results are entered in the victim's permanent medical records. Subsequently, this information could be used in court processes.
- The use of insurance for HIV testing and treatment can result in victims being identified as "high risk" and having to pay higher premiums. This can also complicate their process of obtaining new insurance. If their HIV status is labeled a "pre-existing condition," coverage may be severely limited, therefore limiting eligible critical services and treatment.
- The costs of HIV prophylactic treatment can be astronomical. Even if states have victims' compensation programs, victims are often required to pay for services upfront and wait for reimbursement. Paying upwards of $1,000 out of pocket for treatment is simply not possible for many victims.
- Not all emergency room personnel have been properly trained in HIV testing counseling.
- While some studies show nPEP to be effective in preventing HIV among individuals exposed in the workplace, research on the efficacy of nPEP remains inconclusive.

Victims' fears of HIV infection

Although the risk of developing HIV from a single sexual assault is low, there remains a potential risk of HIV transmission. Because of this, a sexual assault victim/survivor has valid concerns about the risk of HIV infection. A victim/survivor may have these fears either at the time of the rape or afterwards. Sexual violence not only places individuals at risk for HIV infection; sexual violence can also exacerbate an existing HIV infection. An HIV positive victim of sexual violence may be exposed to various viruses and infections, including different strains of HIV, via the perpetrator. These exposures can seriously compromise the victim's treatment outcomes and health status.

The degree of fear regarding HIV exposure is often related to the relationship of the perpetrator to the victim. According to one study, women who report extreme fear or concern about contracting HIV are likely to be those who are raped by strangers rather than those who are raped by non-strangers (Resnick, et al., 2002). Although this study involved only female victims, male victims of sexual assault may experience similar fears of contracting HIV.

Testing perpetrators

State statutes vary regarding HIV testing of sex offenders, reflecting an ongoing debate. This debate involves the constitutional rights of the offender, the unforeseen drawbacks that testing perpetrators may have on victims, public health concerns, and human rights issues.

The following resources provide more information on testing sex offenders for HIV and the rights of victims of sex crimes:

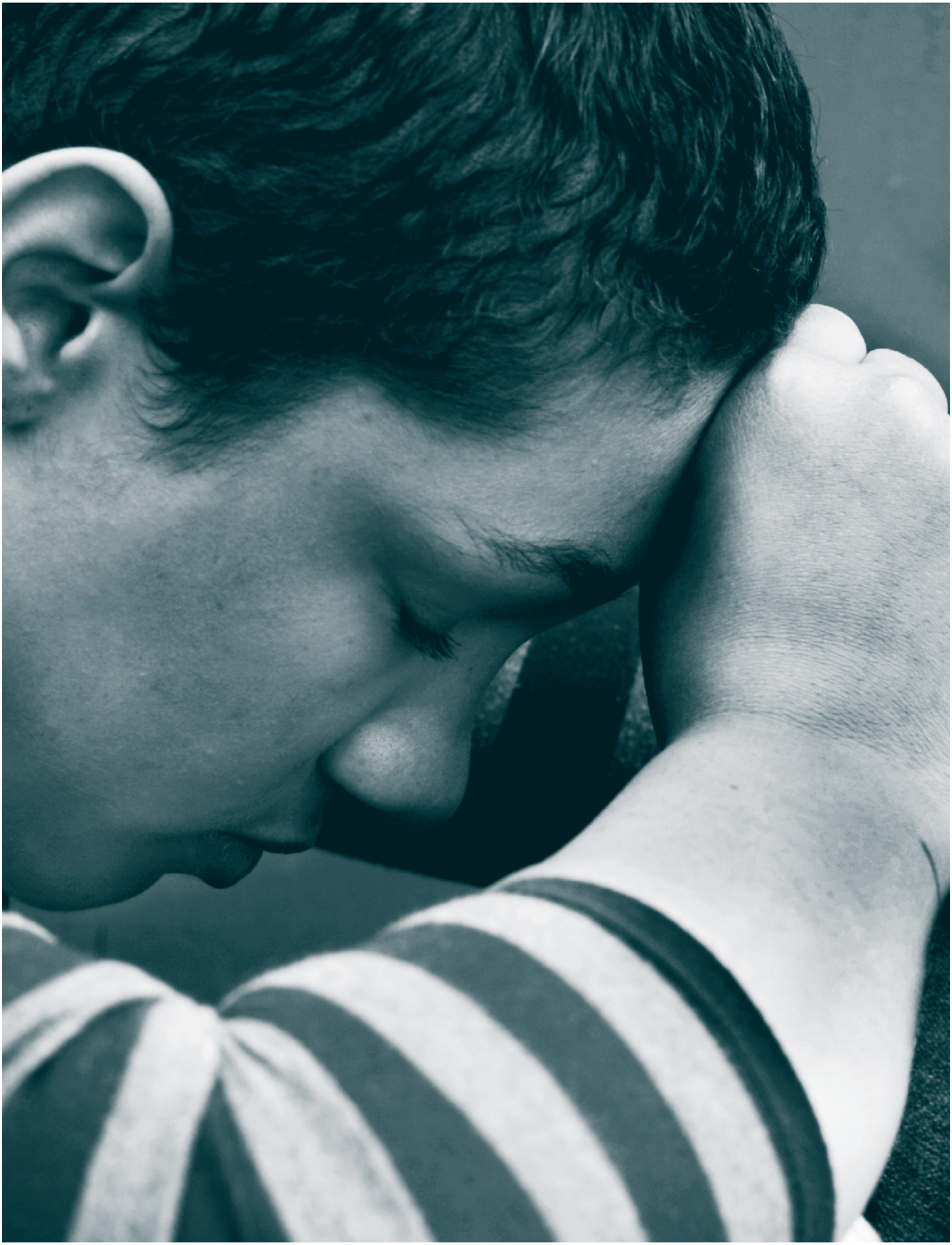
- **HIV Testing and Sex Crimes: Summary of State Laws, 2005,** This chart outlines the rights of victims of sex crimes with regards to HIV testing of the offender and the victim in the United States, the District of Columbia, and the US Territories. Available through the National Sexual Violance Resource Center.

- **1996 Victims Rights Sourcebook,** This sourcebook provides information about the rights of crime victims, including charts on victim-related legislation (through 1995) on a state-by- state basis. Available through National Center for Victims of Crime.

How service providers can assist victims

Victim service providers can assist a victim in reducing his or her fear of developing HIV and making informed decisions about testing and treatment. The following considerations can assist service providers in meeting the needs of sexual assault victims.

- Stay informed about HIV, sexual assault, and resources.
- Develop an ongoing understanding of how HIV, sexual assault, and related social oppressions are connected.
- Know the different testing options available in your community. Give victims/survivors accurate information and support them in their decision-making process.
- Listen without judgment. Do not make assumptions.
- Identify and refer victims/survivors to known and credible agencies and resources that can provide them with further information and support about sexual violence and HIV.
- Develop an awareness and understanding of legal and ethical obligations pertaining to confidentiality regarding sexual violence and HIV.
- Find ways to maintain victim/survivor confidentiality and privacy, especially in small communities regarding sexual violence victimization and HIV status.
- When appropriate, address HIV issues, including HIV status, HIV risk, risk reduction, HIV testing, and treatment with victims/survivors.
- Remember, HIV testing is only one part of the continuum of care and support available to victims/survivors.
- Collaborate with health care professionals to develop victim sensitive policies and resources, including appropriate pre-test counseling policies and resources.
- Engage in cross-training with health care and other allied professionals to expand the community's knowledge and skills about sexual violence and HIV.
- Stay abreast of public policies pertaining to HIV testing and treatment options in your state and how such policies impact victims/survivors.



Resources

The following resources provide further information on HIV/AIDS and/or sexual violence:

AIDS.org website
www.aids.org/FactSheets/154-pep.html

American Civil Liberties Union
www.aclu.org/hiv/index.html

CDC-INFO:
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348
In English, en Espanol 24 Hours/Day

CDC National Prevention Information Network:
Rockville, Maryland 20849-6003
1-800-458-5231
www.cdcnpin.org

Centers for Disease Control and Prevention, information on HIV/AIDS:
www.cdc.gov/hiv/dhap.htm

Centers for Disease Control and Prevention, State and Local HIV/AIDS surveillance reports:
www.cdc.gov/hiv/topics/surveillance/resources/reports/2004report/webaddress.htm

Gender and HIV/AIDS Electronic Library
www.genderandaids.org

Jane Doe Inc., the Massachusetts Coalition Against Sexual Assault and Domestic Violence, Sexual Assault, Domestic Violence, & HIV/AIDS:
Services, Safety, & Resources, A Guide for Providers
617-248-0922
www.janedoe.org

Kaiser Foundation Network
www.kaisernerwork.org/static/spotlight_hivaids_index.cfm

National Center for Victims of Crime
202-467-8700
www.ncvc.org

A National Protocol for Sexual Assault Medical Forensic Examinations
U.S. Department of Justice, Office on Violence against Women
www.ncjrs.org/pdffiles1/ovw/206554.pdf

National Resource Center on Domestic Violence
1-800-537-2238
www.nrcdv.org

National Sexual Violence Resource Center
1-877-739-3895
www.nsvrc.org

nPEP State Policies

The following public health agencies/departments have developed nPEP policies and protocols for their states:
New York State AIDS Institute, the San Francisco County Health Department, the Massachusetts Department of Public Health, the Rhode Island Department of Health, and the California State Office of AIDS. Contact the National Sexual Violence Resource Center for copies at 1-877-739-3895 or nsvrc.org.

UNAIDS
www.unaids.org/

U.S. Department of Health & Human Resources & Services Administration, HIV/AIDS Bureau Guide to the Clinical Care of Women with HIV/AIDS with Resources
www.hab.hrsa.gov

World Health Organization
www.who.int/en/ http://www.who.int/topics/hiv_infections/en/

References

Centers for Disease Control and Prevention. (2003) HIV/AIDS surveillance report 2003.
Retrieved November 15, 2006 from www.cdc.gov/hiv/topics/surveillance/resources/reports/2003report/default.htm.

Centers for Disease Control and Prevention. (2005)
HIV/AIDS surveillance report: Cases of HIV infection and AIDS in the United States and dependent areas, 2005. Retrieved February 28, 2007 from ht www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/pdf/2005SurveillanceReport.pdf.

Centers for Disease Control and Prevention. (2005)
Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States. MMWR, January 21, 2005 / 54(RR02); 1-20. Atlanta, GA: Centers for Disease Control and Prevention. (available at: www.cdc.gov/mmwr/PDF/rr/rr5402.pdf).

Centers for Disease Control and Prevention. (2006a)
A glance at the HIV/AIDS epidemic, Retrieved January 30, 2006 from www.cdc.gov/hiv/PUBS/Facts/At-A-Glance.htm.

Centers for Disease Control and Prevention. (2006b)
HIV/AIDS among African Americans, Retrieved January 30, 2006 from www.cdc.gov/hiv/topics/aa/resources/factsheets/pdf/aa.pdf.

Centers for Disease Control and Prevention. (2006c)
HIV/AIDS among Hispanics, Retrieved April 5, 2006 from www.cdc.gov/hiv/pubs/Facts/hispanic.htm.

Centers for Disease Control and Prevention. (2006d)
HIV/AIDS among men who have sex with men, Retrieved April 5, 2006 from www.cdc.gov/hiv/PUBS/Facts/msm.htm

Centers for Disease Control and Prevention. (2006e)
HIV/AIDS among women. Retrieved March 17, 2006 from www.cdc.gov/hiv/pubs/facts/women.htm

Centers for Disease Control and Prevention (2006f)
HIV/AIDS among women who have sex with women. Retrieved November 15, 2006 www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/wsw.pdf.

Centers for Disease Control and Prevention, (2006g)
Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. Retrieved February 19, 2007 from www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm?s_cid=rr5514a1_x.

Centers for Disease Control and Prevention. (2006h)
Sexually transmitted diseases: Treatment guidelines 2006. Retrieved November 17, 2006 from www.cdc.gov/std/treatment/2006/sexual-assault.htm#hivrisk.

Centers for Disease Control and Prevention. (2006i)
Sexually transmitted diseases treatment guidelines 2006: Sexual assault and STDs. Retrieved February 19, 2007 from www.cdc.gov/ncipc/factsheets/svoverview.htm.

Centers for Disease Control and Prevention (2006j)
Sexual violence overview, Retrieved August 30, 2006 from www.cdc.gov/ncipc/factsheets/svoverview.htm.

Centers for Disease Control and Prevention. (2007)
HIV and its transmission. Retrieved February 15, 2007 from www.cdc.gov/hiv/resources/factsheets/transmission.html

Council on Scientific Affairs, American Medical Association. (1996)
Health care needs of gay men and lesbians in the United States. JAMA, 275 (17), pp. 1354-1359.

Farley, M. (2000)
Prostitution: Factsheet on human rights violations. Retrieved September 15, 2006 from www.prostitutionresearch.com/factsheet.html.

Finkelhor, D., Hotaling, G., Lewis, I. & Smith, C. (1990)
Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. Child Abuse and Neglect, 14, pp. 19-28.

Henry Kaiser Family Foundation. (2006)
Women and HIV/AIDS in the United States. Retrieved March 17, 2006 from www.kff.org/hivaids/6092cfm.

Jewkes, R., Sen, P., & Garcia-Moreno, C. (2002)
Sexual violence. In: Krug E., Dahlberg, L., Mercy, J.A., Zwi, A.B., Lozano, R. (Eds.), World Report of Violence and Health (pp.147-181). Geneva, Swtizerland: The World Health Organization.

NASTAD, (2006) Women and HIV/AIDS: A focus on women of color.
Retrieved January 30, 2006 from www.nastad.org/documents/public/pub_prevention/200621 February2006HVPreventionBulletin.pdf.

National HIV Testing Resources. (2006)
Frequently asked questions about HIV and HIV testing. Retrieved September 15, 2006 from www.hivtest.org/subindex.cfm?FuseAction=FAQ#2.

National Institutes of Health. (2005)
HIV infection and AIDS: An overview. Retrieved February 15, 2007 from www.niaid.nih.gov/factsheets/hivinf.htm

Norton-Hawk, M.A. (2002) The lifecourse of prostitution.
Sexual Assault Report, March/April 2002, pp. 51, 52, 61.

Resnick, et al. (2002)
Rape-related HIV risk concerns among recent rape victims, Journal of Interpersonal Violence, 17 (2): pp. 752.

Runyan, D., et al. (2002)
Child abuse and neglect by parents and other caregivers. In: Krug E., Dahlberg, L., Mercy, J.A., Zwi, A.B., Lozano, R. (Eds.), World Report of Violence and Health (pp.147-181). Geneva, Switzerland: The World Health Organization.

UNAIDS. (2004) 2004 Report on the global AIDS epidemic.
Retrieved November 16, 2006 www.unaids.org/bangkok2004/GAR2004_pdf/UNAIDSGlobalReport2004_en.pdf.

UNAIDS & WHO. (2005) Aids epidemic update.
Retrieved January 30, 2006 from www.who.int/hiv/epi-update2005_en.pdf.

Wyatt, G.E. (2005)
HIV-positive black women with histories of childhood sexual abuse: Patterns of substance use and barriers to health care. Journal of Health Care for the Poor and Underserved, 16:4, pp. 9-23.

World Health Organization. (2000) Human rights, women and HIV/AIDS.
Retrieved November 16, 2006 from www.who.int/mediacentre/factsheets/fs247/en/print.html.

National Sexual Violence Resource Center

The National Sexual Violence Resource Center (NSVRC), founded by the Pennsylvania Coalition Against Rape, opened in July 2000 as the nation's principle information and resource center regarding all aspects of sexual violence. The NSVRC provides national leadership in the anti-sexual violence movement by generating and facilitating the development and flow of information on sexual violence intervention and prevention strategies. The NSVRC's work is supported in large part with funds from the Centers for Disease Control and Prevention (CDC).

www.nsvrc.org

NSVRC
123 North Enola Drive, Enola, PA 17025
Toll free: 877-739-3895
resources@nsvrc.org

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