Trauma and Violence Aware Care:

Canadian Webinar Series on Implementing the WHO Guidelines on Sexual and Reproductive Health and Rights for Women Living with HIV

Date: Wednesday, September 13, 2017

Time: Time: 9-10:30am PST / 10-11:30am MST /12-1:30pm EST / 6-7:30pm Geneva

Link: https://attendee.gotowebinar.com/register/4131644024420600833

Webinar series hosted in collaboration with:

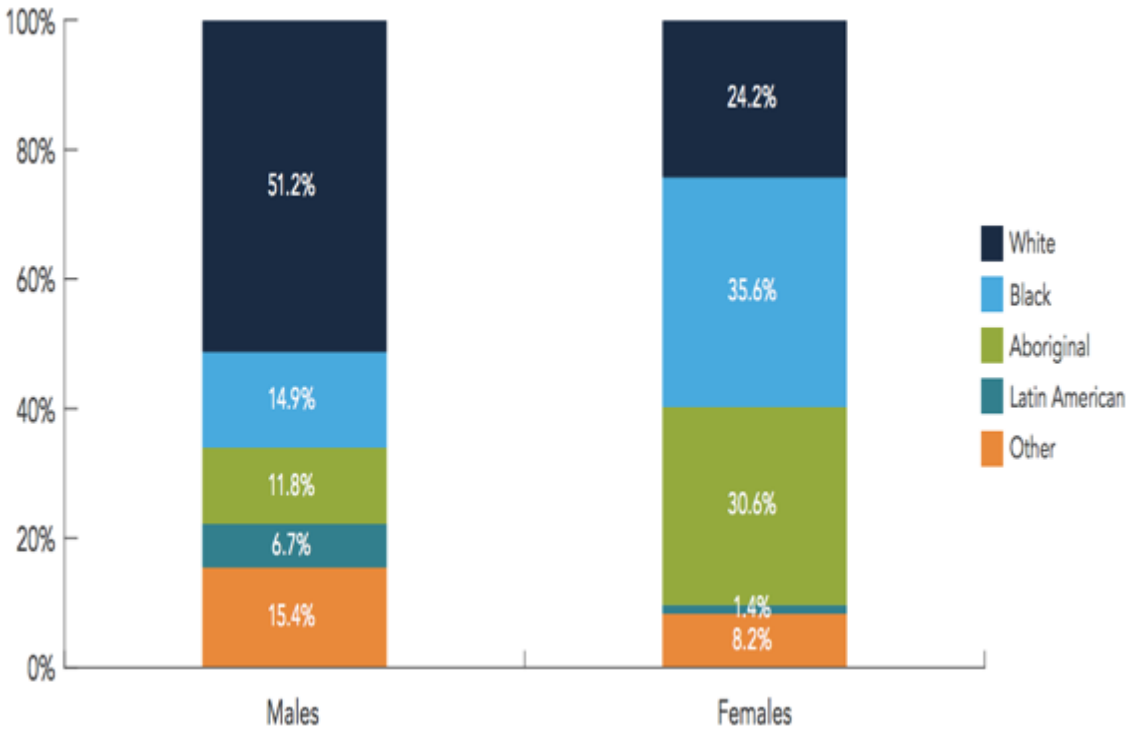
CHIWOS, Canadian Positive People's Network, Oak Tree Clinic, Women's Health in Women's Hands, Canadian Aboriginal AIDS Network (CAAN), WHO, HRP and the IBP Initiative

Remembering

HIV Among Women in Canada

- Women represent nearly one-quarter (23%) of the 75,500 people living with HIV in Canada.
- In 2011, 26% of new HIV infections in Canada were among women (double what it was in 1999) (PHAC 2014)

Fig 1. HIV by Sex and Race/Ethnicity – Canada, 2014



Trauma Aware Care

- Becoming "trauma-informed" means recognizing that people often have many different types of trauma in their lives. People who have been traumatized need support and understanding from those around them. Often, trauma survivors can be re-traumatized by well-meaning caregivers and community service providers.
  - traumainformedcareproject.org

Webinar Objectives

- **Provide an overview** of current research about **trauma and violence aware care** in Canada context using data from the Canadian HIV Women's Sexual and Reproductive Health Cohort Study (CHIWOS).
- **Respond** to recommendations provided by the WHO Consolidated Guidelines of the Sexual and Reproductive Health and Rights of Women living with HIV (attached)
- **Gain feedback on best practices** from national stakeholders regarding the implementation of health care services to support women living with HIV experiencing trauma and violence.
- **Gain insights** from women living with HIV to highlight gaps in research and priority areas for further attention.
- **Develop an action plan on trauma and violence aware care** for the Canadian context

World Health Organization | CHIWOS | BC WOMEN'S HOSPITAL+ HEALTH CENTRE | CRCPN | WOMEN'S HEALTH IN WOMEN'S HANDS COMMUNITY HEALTH CENTRE | human reproduction programme hrp research for impact | IBP Initiative Scaling up what works in family planning/reproductive health

Today's Speakers

Elder Valerie Nicholson

Dr. Angela Kaida

Dr. Manjulaa Narasimhan

Dr. Carmen Logie

Dr. Jesleen Rana

Dr. Neora Pick

Jay MacGillivray

Tracey Conway

Wangari Tharao

World Health Organization

CHIWOS

BC WOMEN'S HOSPITAL+ HEALTH CENTRE

CRCPP+ CRCPP+

WOMEN'S HEALTH IN WOMEN'S HANDS COMMUNITY HEALTH CENTRE

human reproduction programme hrp research for impact

IBP Initiative Scaling up what works in family planning/reproductive health

Overview of the Agenda

Time	Title of Presentation	Presenter	Affiliation
9:10-9:20 PST 10:10-10:20MST 12:10-2:10EST	Consolidated guidelines on sexual and reproductive health and rights of Women Living with HIV	Dr. Manjulaa Narasimhan	World Health Organization – Department of Reproductive Health
9:20-9:30 PST 10:20-10:30MST 12:20-2:30EST	Current overview of research: Gender-Based Violence and Trauma among women living with HIV in Canada	Dr. Carmen Logie	University of Toronto, Factor-Inwentash Faculty of Social Work
Implementation 9:30-10:05 PST 10:30-11:05MST 12:30-1:05EST	Violence and Trauma Aware Care	Dr. Jesleen Rana	Women's Health in Women's Hands Community Health Centre
	Trauma Aware Clinical Care	Jay MacGillivray	Positive Pregnancy Program
	Trauma and Violence Aware Care	Dr. Neora Pick	Oak Tree Clinic, British Columbia Women's Hospital
	Meaningful Involvement of Women living with HIV (MIWA)	Tracey Conway	Canadian Positive People's Network
	Immigrant, refugee and non-status women living with HIV	Wangari Tharao	Women's Health in Women's Hands Community Health Centre
	Indigenous Women living with HIV	Valerie + Tracey	Canadian Aboriginal AIDS Network
10:05-10:30 PST 11:05-11:30MST 1:05-2:30EST	Discussion & Next Steps		

Housekeeping

1. Asking questions

- During presentations, please submit any questions using the text feature of the application
- We have allotted 20 minutes at the end of the webinar for discuss and Q&A
- If you are joining us on the phone, please send any comments or questions to BC CHIWOS coordinator Becky (rgormley@cfenet.ubc.ca)
- If we do not get to answer or discuss all questions posed during the webinar, the organizing team will collate the questions and send responses to all webinar attendees after the webinar. Questions & answers will also be posted online with the recorded version of the webinar.
- Please type any technical difficulties into the text feature.

2. Webinar recording

- This webinar will be recorded and posted on the IBP Channel and the WHO RHR Youtube Channel. Links will be posted at the end of the webinar.

3. Handouts

- There are handouts that you can download for your own viewing and reference

Conflict of Interest

Today's webinar presenters have no conflicts of interest to declare.

World Health Organization

Consolidated guideline on **sexual and reproductive health and rights of women living with HIV**

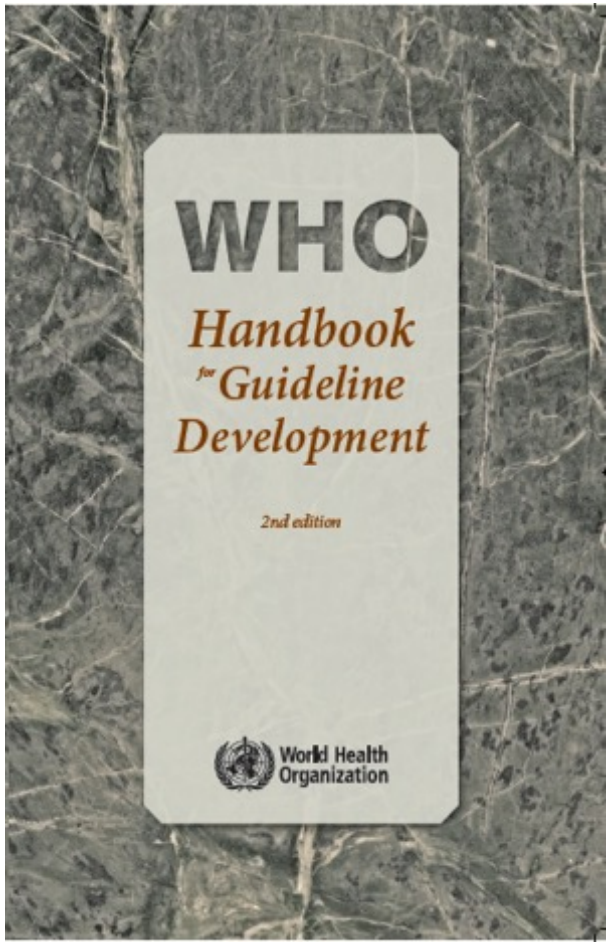
human reproduction programme hrp research for impact
UNDP·UNFPA·UNICEF·WHO·WORLD BANK

UNAIDS

UNFPA

UNITED NATIONS HUMAN RIGHTS
OFFICE OF THE HIGH COMMISSIONER

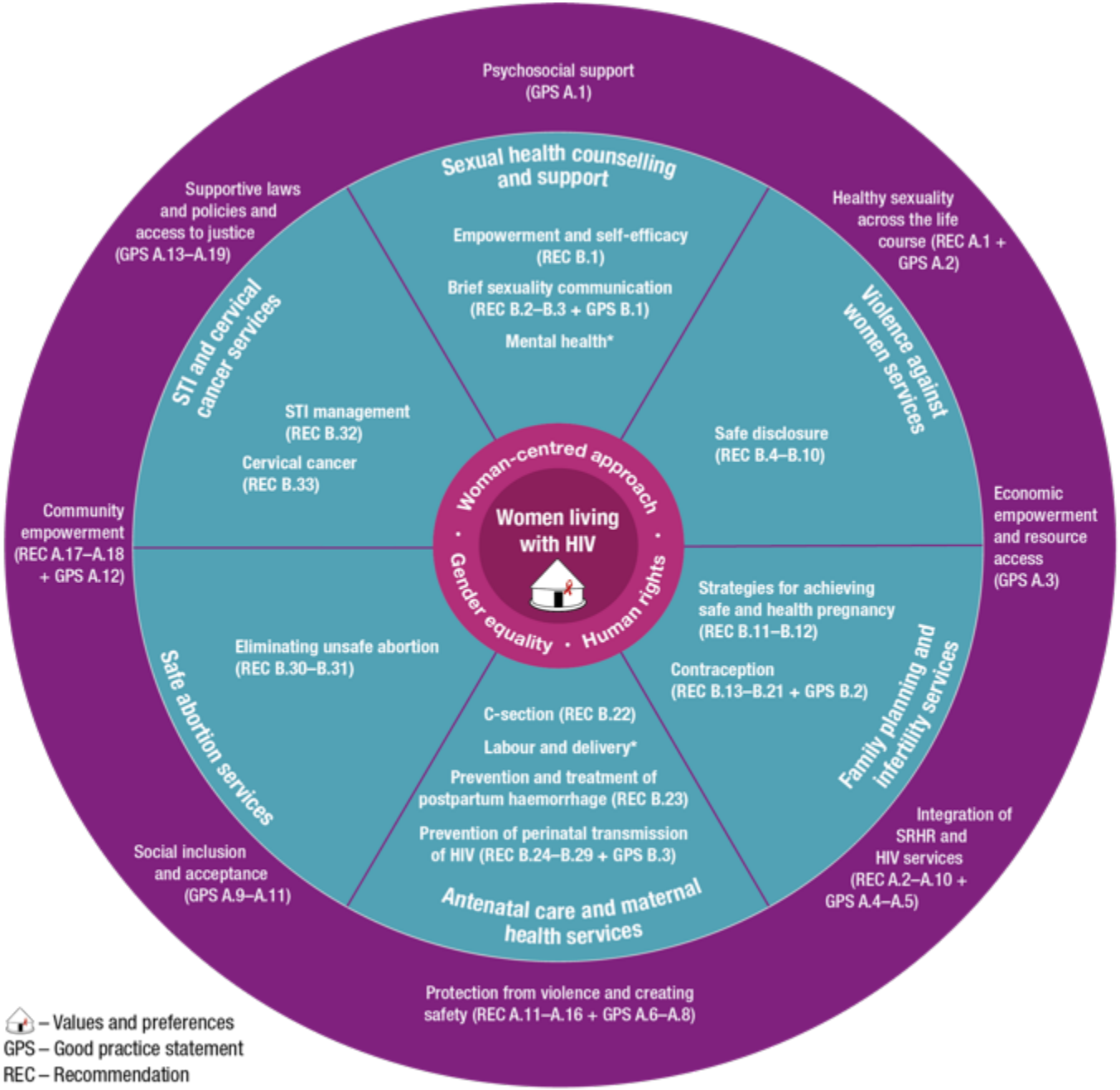
What is a WHO guideline?



- "A **WHO guideline** is any document, whatever its title, that contains WHO recommendations about health interventions, whether they be clinical, public health or policy interventions."
- "A **recommendation** provides information about what policy-makers, health-care providers or patients should do. It implies a choice between different interventions that have an impact on health and that have ramifications for the use of resources."

Guiding principles

- **Woman-centred approach**
- **promotion of human rights**
- **gender equality**

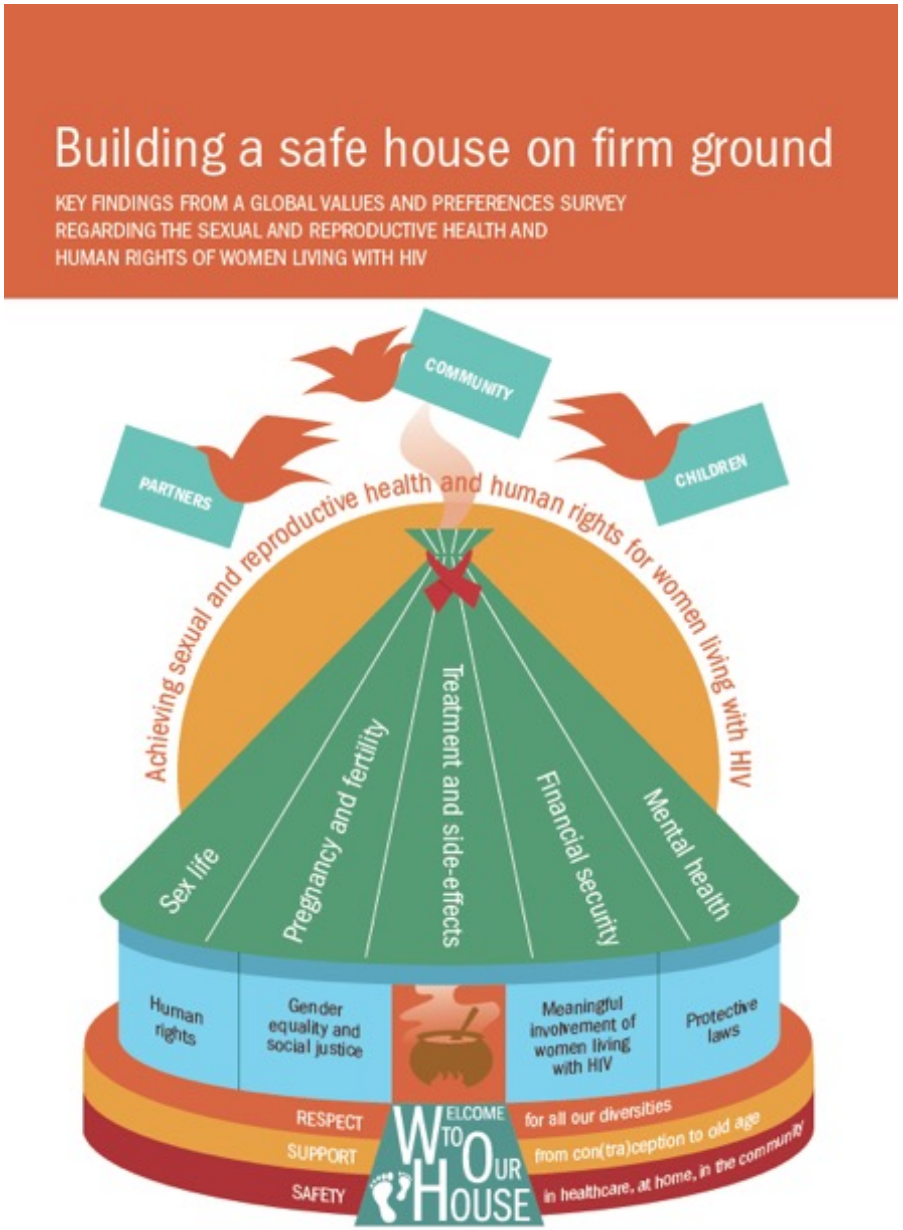


– Values and preferences
GPS – Good practice statement
REC – Recommendation
– Enabling environment
– Health interventions

C-section: caesarean section; SRHR: sexual and reproductive health and rights; STI: sexually transmitted infection.

* For sections on "Mental health" and "Labour and delivery", this guideline does not include any RECs or GPSs but refers to existing WHO guidance.

Meaningful Community Engagement

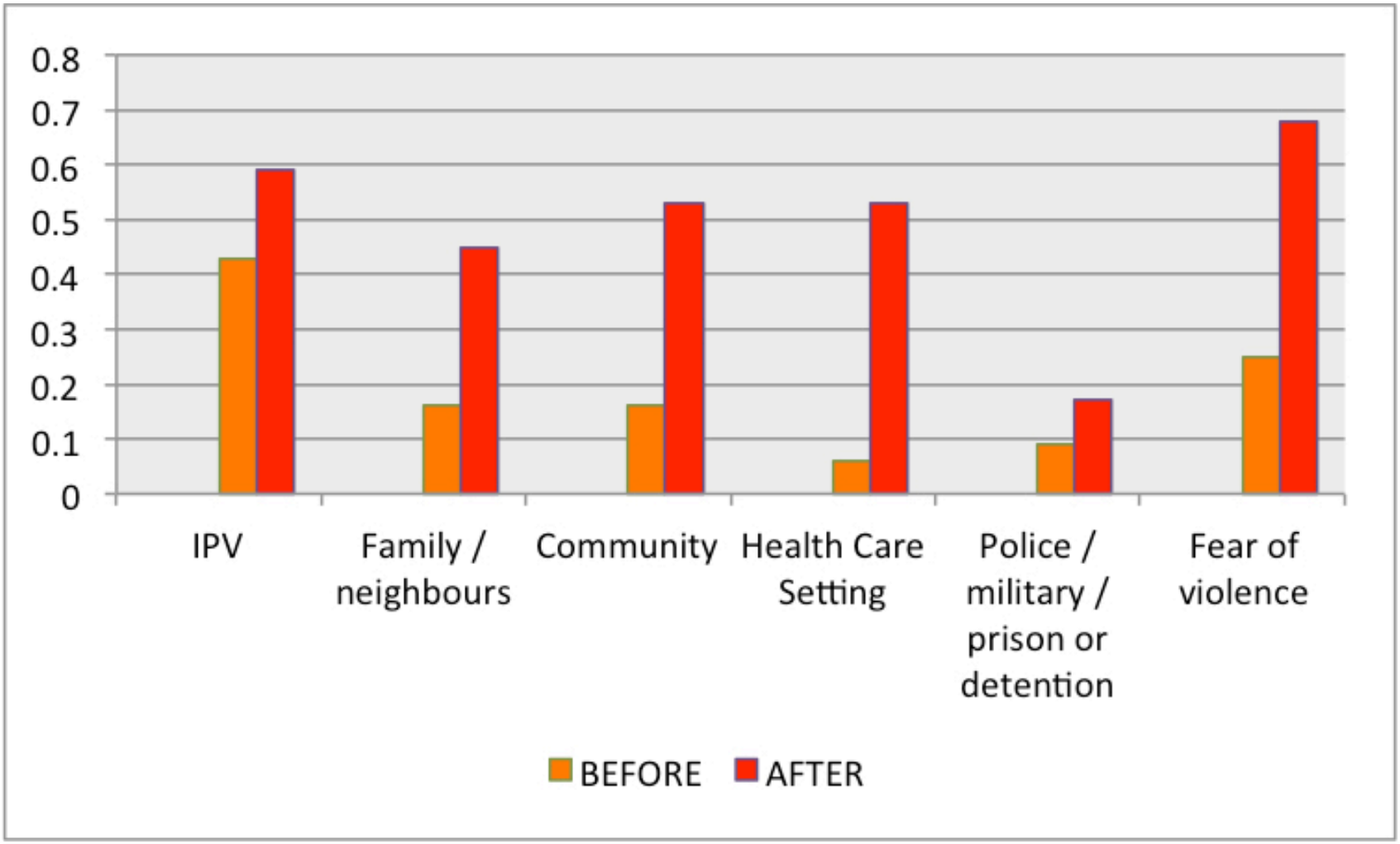


- **Core Team Members: Luisa Orza, Alice Welbourn, Susan Bewley, E. Tyler Crone, Marijo Vazquez**

- **GRG members: Nukshinaro Ao, Cecilia Chung, Sophie Dilmitis, Calorine Kenkem, Svetlana Moroz, Suzette Moses-Burton, Hajjarah Nagadya, Angelina Namiba, L'Orangelis Thomas Negrón, Gracia Violeta Ross, Sophie Strachan, Martha Tholanah, Patricia Ukoli, Rita Wahab.**

http://salamandertrust.net/wp-content/uploads/2016/09/BuildingASafeHouseOnFirmGroundFINALreport190115.pdf

Trauma and violence experienced by women living with HIV – outcomes of the largest global community survey on SRHR priorities of women living with HIV



ref: http://www.jiasociety.org/index.php/jias/article/view/20285/html

Effective **Implementation**

Action on the recommendations in this guideline requires a strategy that is informed by evidence, appropriate to the local context, and responsive to the needs and rights of women living with HIV.

Gender-based violence and trauma among women living with HIV in Canada

Carmen Logie, PhD
Assistant Professor
Factor-Inwentash Faculty of Social Work
University of Toronto, Toronto

CHIWOS
Canadian HIV Women's Sexual and Reproductive Health Cohort Study

UNIVERSITY OF TORONTO

FACTOR-INWENTASH FACULTY OF SOCIAL WORK

Background: gender based violence (GBV)

- What is GBV? *"any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services."* (UNHCR)
- Globally women and girls experience GBV that compromises wellbeing (Garcia-Morena et al., 2015)
- GBV & HIV: *GBV a risk factor for HIV acquisition (Dunkle et al., 2013) & there is a high rate of GBV among women living with HIV following diagnosis* *(Orza et al., 2015)*
- Syndemics approaches examine multiple, co-occurring deleterious psychosocial and structural factors that impact individual/population health (Singer, 2003)
- SAVA syndemic: substance use, violence, HIV & AIDS (Sullivan et al., 2015)

CHIWOS

Objectives

- To assess the prevalence of experiencing GBV in adulthood among women living with HIV (WLWH)
- Which priority populations have higher prevalence of GBV?
- How does violence function to increase risk of both HIV acquisition (forced sex data) and compromise access to care (violence study with clinical outcomes)?
- What is the prevalence of trauma?

CHIWOS

Methods

- CHIWOS, baseline data from longitudinal cohort study
- Community-based research, Multi-centred (ON, QB, BC)
- Non-random, purposive sampling:
  - peer research assistant networks, word-of-mouth
  - HIV clinics; AIDS Service Organizations; CBO
  - provincial CHIWOS Community Advisory Board networks; CHIWOS National Steering Committee networks;
  - Social media
- GBV assessed through self-reported experiences of control, physical, sexual, or verbal abuse ever in adulthood (>16 years) *(could be completed privately)*
- Unadjusted univariable and adjusted multivariable logistic regression to identify factors associated with having experienced any GBV, and each type of violence *separately*

CHIWOS

Forced sex as a self-reported mode of HIV acquisition among women living with HIV in Canada

- Forced sex was reported by 16.5% (n=219) as the mode of HIV acquisition; third most dominant mode of HIV acquisition (Logie et al., 2017)
  - 51.6% consensual sex, 19.7% sharing needles, 5.3% blood transfusion, 3.8% perinatal, 1.3% contaminated needles, 0.4% other, 1.6% do not know/prefer not to answer

- Factors associated with reporting HIV acquisition from forced vs. consensual sex:
  - landed immigrant or refugee vs. Canadian citizen
  - African, Caribbean or Black ethnicity vs. white/Caucasian
  - Post-traumatic stress disorder symptoms (PTSD)
  - History of group home or foster care residence

- Forced sex is a significant underrecognized risk factor and mode of women's HIV acquisition and needs to be recognized in surveillance systems and clinical screening practices

CHIWOS

Table 1. Prevalence of experiences of adulthood violence among women with HIV in Canada (n=1312)

Experienced violence in adulthood (>16 years old)	N (%)
Any type of violence	1054 (80)
Physical violence	817 (74)
Sexual violence	579 (44)
Verbal violence	973 (74)
Control	608 (46)

CHIWOS

Table 2. Socio-demographic factors associated with experiences of adulthood violence among women with HIV in Canada (n=1312)

Factor	Overall N (%)	Any violence n (%)	No violence n (%)	P-value
Ethnicity: Indigenous	290 (22)	247 (23)	43 (17)	<0.001
ACB	367 (28)	269 (26)	98 (38)	
Caucasian	557 (42)	457 (43)	100 (39)	
Other	98 (7)	81 (8)	17 (7)	
Province: British Columbia	329 (25)	316 (30)	13 (5)	<0.001
Ontario	655 (50)	469 (44)	186 (72)	
Quebec	328 (25)	269 (26)	59 (23)	
Income: <$20,000	918 (72)	760 (73)	158 (64)	<0.001
$20K-$40K	228 (18)	184 (18)	44 (18)	
>$40K	136 (11)	91 (9)	45 (18)	

Factors associated with experiences of adulthood violence among women with HIV in Canada (n=1312)

Adjusting for age, ethnicity, education and income, experiencing any form of GBV in adulthood was associated with:

- **HIV care outcomes**: Delayed access to HIV care
- **Substance use:** current tobacco and previous cannabis use
- Higher levels of **racial discrimination**
- **Incarceration history**
- **Current symptoms of PTSD**

→ ***women with histories of violence have higher independent odds of having current symptoms of PTSD***

Post-Traumatic Stress Symptoms

- Among 1406 participants, post-traumatic stress symptoms (PTSS) were reported in: British Columbia (55.9%), Ontario (39.1%) and Québec (53.9%)

- PTSS associated with different factors in each province:
  - BC: never having been on antiretroviral medication, less current injection drug use, gender discrimination
  - Ontario: refugee/immigrant status vs. citizen or permanent resident; acquiring HIV from forced sex, gender discrimination, HIV stigma
  - Quebec: lower ability to disclose HIV diagnoses, food insecurity, history of incarceration

- **Need for targeted trauma informed practice**

CHIWOS

Discussion

- Forced sex was the third dominant mode of HIV transmission at 16.5% (n = 219)
  - Associated with legal status (landed immigrant, refugee), ethnicity (African, Caribbean or Black vs. Caucasian), mental health (PTSD), and childhood experiences (group home, foster care)

- Most (80%) women with HIV in Canada experienced violence in adulthood
  - **Physical (62%), sexual (44%), verbal (74%), emotional/control (46%)**

- What differs when we look at type of violence?
  - *Sharing needles* associated with **control & sexual violence**
  - *Gender discrimination* associated with **sexual violence**
  - *HIV-related stigma* associated with **control violence**

→ **Violence was associated with poorer clinical, mental health and social outcomes**

- *HIV care* (delayed access to care), *Mental health & substance use* (PTSD symptoms, current/former cigarette use, previous cannabis use), *Social disparities* (racial discrimination, lifetime incarceration)

Recommendations

- *Recommendations for Practice:*
  - trauma informed
  - address PTSD
  - harm reduction
  - screen for GBV
  - linkages to care and support

- *Recommendations for Action:*
  - challenge & reduce GBV
  - community & policy approaches, and intersectional stigma & discrimination
  - considerations for the complexity of types of violence, high prevalence of violence, and **syndemic** of violence, mental health issues, substance use & social inequities

References

1. Dunkle KL, Decker MR. Gender-Based Violence and HIV: Reviewing the Evidence for Links and Causal Pathways in the General Population and High-risk Groups. American Journal of Reproductive Immunology. 2013;69:20-6.
2. García-Moreno C, Zimmerman C, Morris-Gehring A, Heise L, Amin A, Abrahams N, et al. Addressing violence against women: a call to action. The Lancet. 2015;385(9978):1685-95.
3. Logie C, Kaida A, de Pokomandy A, O'Brien N, O'Campo P, MacGillivray J, Ahmed U, Arora N, Wang L, Jabbari S, Kennedy L, Carter A, Proulx-Boucher K, Conway T, Sereda P, Loutfy M. Prevalence and Correlates of Forced Sex as a Self-Reported Mode of HIV Acquisition Among a Cohort of Women Living With HIV in Canada. J Interpersonal Violence 2017, https://doi.org/10.1177/0886260517718832
4. Orza L, Bewley S, Chung C, Crone ET, Nagadya H, Vazquez M, et al. "Violence. Enough already": findings from a global participatory survey among women living with HIV. J Int AIDS Soc. 2015;18(Suppl 5):20285.
5. Singer M, Clair S. Syndemics and Public Health: Reconceptualizing Disease in Bio-Social Context. Med Anthropol Q. 2003;17(4):423-41.
6. Sullivan KA, Messer LC, Quinlivan EB. Substance abuse, violence, and HIV/AIDS (SAVA) syndemic effects on viral suppression among HIV positive women of color. AIDS Patient Care STDS. 2015;29(S1):S42-S8.

Thank you!

- Acknowledgements: CHIWOS team and participants
- Support from Ontario Ministry of Research & Innovation Early Researcher Award

- Contact: Carmen Logie

Carmen.logie@utoronto.ca

https://www.facebook.com/CHIWOS

@CHIWOSresearch on Twitter

Trauma and Violence Aware Care: Canadian Webinar Series on Implementing the WHO Guidelines on Sexual and Reproductive Health and Rights for Women Living with HIV

Implementation

DR. JESLEEN RANA

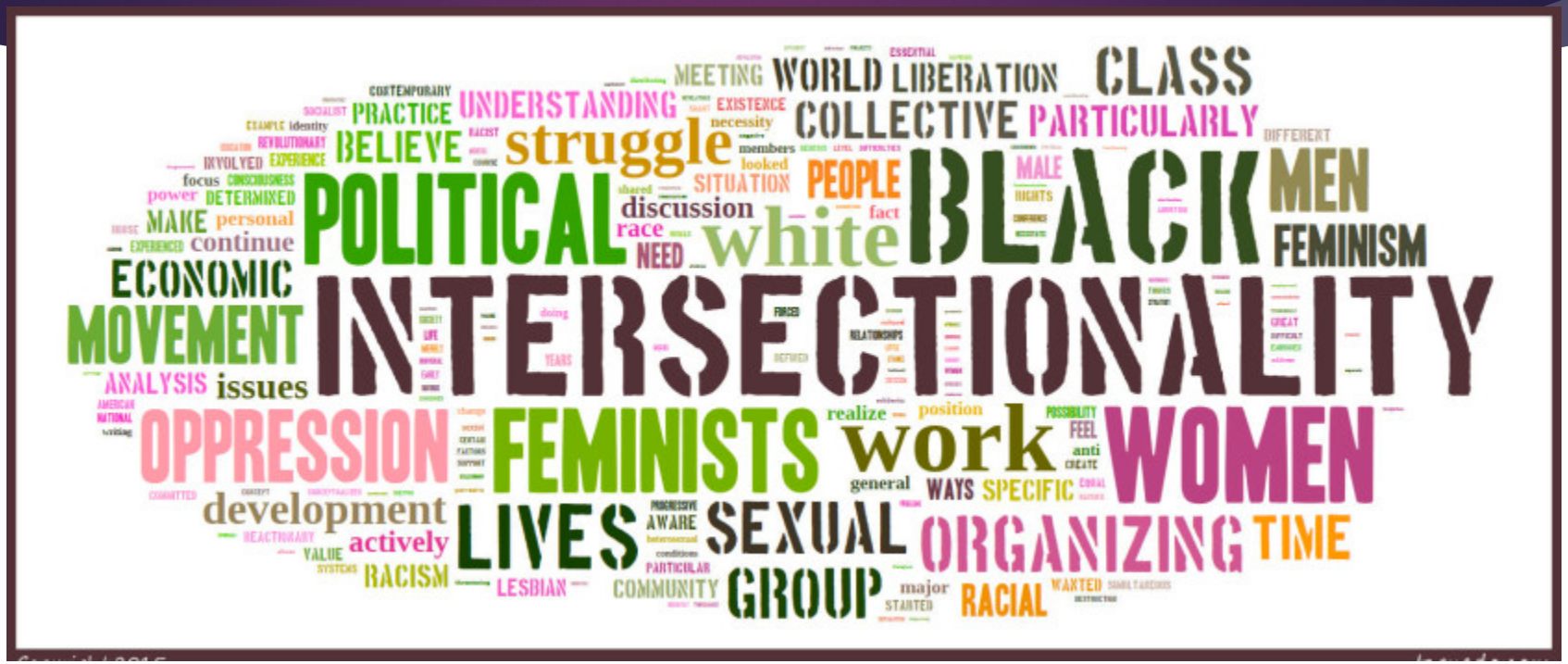
WOMEN'S HEALTH IN WOMEN'S HANDS COMMUNITY HEALTH CENTRE

Reflecting on our reality

- 40% of individuals globally are unaware of their HIV status
  - >14 million people
  - Disparities are greater in some communities
- Is this a reflection of how the 'system failed' them?
  - What does this mean for US as practitioners within the 'system'?

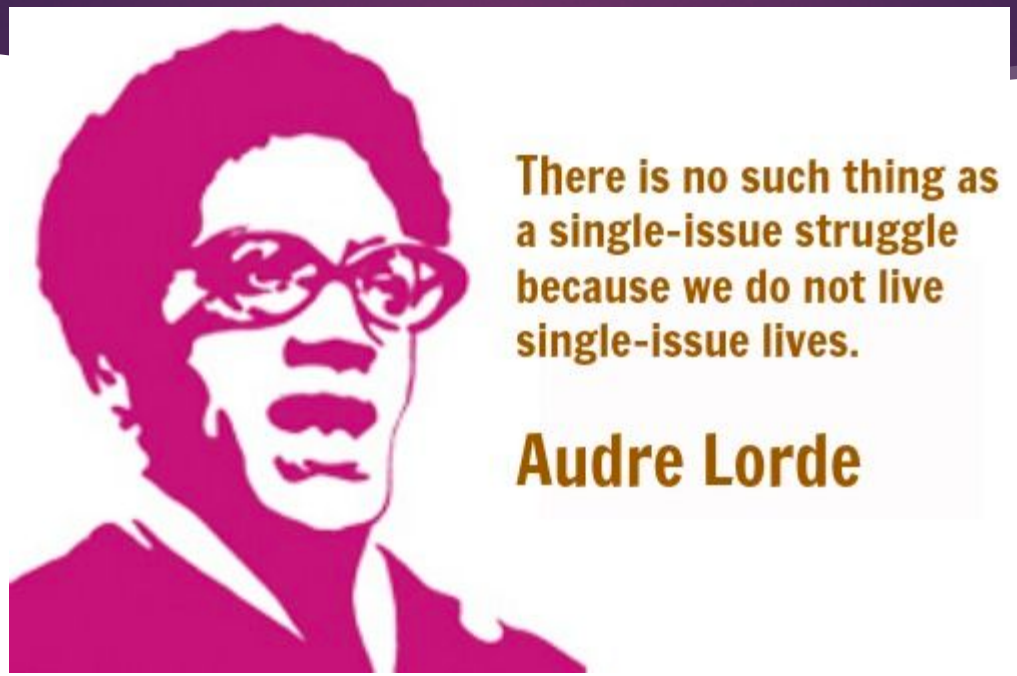
History of Medicine

- Where are our practices rooted?
- How are we influenced by historical practices?
- 'Race' as a social construct used incorrectly in medicine
- Impact of trauma and violence is intergenerational


INTERSECTIONALITY
POLITICAL
BLACK
MEN
FEMINISM
ECONOMIC
MOVEMENT
OPPRESSION
FEMINISTS
work
WOMEN
LIVES
SEXUAL
ORGANIZING
TIME
GROUP
RACIAL
development
actively
RACISM
LESBIAN
COMMUNITY
ANALYSIS
issues
MAKE
personal
continue
power
DETERMINED
focus
CONSCIOUSNESS
REVOLUTIONARY
EVOLVED
EXPERIENCE
BELIEVE
PRACTICE
UNDERSTANDING
struggle
COLLECTIVE
PARTICULARLY
CLASS
LIBERATION
WORLD
MEETING
EXISTENCE
necessity
members
looked
SITUATION
PEOPLE
MALE
RIGHTS
DIFFERENT
discussion
race
NEED
white
fact
realize
position
POSSIBILITY
FEEL
anti
CREATE
general
WAYS
SPECIFIC
major
STARTED
WANTED
AWARE
PROGRESSIVE
PARTICULAR
VALUE
SYSTEMS
REACTIONARY
CONTEMPORARY
SOCIALIST
EXAMPLE
identity
RACIST
ESSENTIAL
FORCES
RELATIONSHIPS
YEARS
GREAT
DIFFICULT
EXPERIENCED
COMMITTED
AMERICAN
NATIONAL

Trauma and Violence Awareness

- Acknowledge the role and impact of trauma and its link to health and health behaviours
- It begins with awareness, willingness to learn, willingness to step outside of 'norm'
- What are 'Trauma-aware' values?
- So, if we are part of the system, what can we do to be trauma and violence aware?
  - Be aware of pathologizing, categorizing
  - Be aware of language
  - Be aware of notions of 'surveillance'
  - ALWAYS use universal precautions for trauma


There is no such thing as
a single-issue struggle
because we do not live
single-issue lives.
Audre Lorde

Trauma-Aware Clinical Care

Jay MacGillivray, Registered Midwife
Positive Pregnancy Program (P3)
St. Michael's Hospital
Toronto, Canada.

Acknowledging truth.

I am on the traditional land of the Huron-Wendat, Petun, Seneca and Mississauga of New Credit River Peoples.

Strength and Resiliency

- Clients are not victims, they are survivors
- People can have remarkable resiliency: don’t ‘poor them’.
- (I believe) Providers aren't the ‘experts’; the client is.
- Clients have found the inner strength to survive remarkably triggering events; *including OUR clinical care.*

Locating Myself

- I am white
- European/settler background
- Cis woman
- Canadian-born, mostly of dominant culture and language.
- I do not live with HIV.

Practice Demographics

- Refugees, many trafficked from conflict zones
- Members of Indigenous communities
- Hx physical, emotional and/or sexual trauma
- Jailed in home countries or during migration
- Forced marriages
- Street-affected or homeless women
- Coerced sex work/survival sex
- Problematic substance use
- Severe mental health issues

What is Trauma?

- Brutal taking away of power
- Silencing
- Ignoring rights
- Objectifying

Colonization

I want to go to Afric-
NAME the country!

Hand back the expertize and power.

My reality

- I do not have HIV
- I have read about social determinants
- I have read about all the side effects of RX
- I have devoted a lot of time to understanding the research for my job.

Their reality

- They live with HIV
- They often live the social determinates
- They live with the all the side effects of RX
- They have devoted a lot of time to understanding the research for their ***life***.

Examine practice routines

What is the patient view of procedure?

How does someone's personal history affect them during care?

Is there an obvious power difference?

How is health care inadvertently triggering?

What steps can be taken to improve safety in health care ?

Clinical routines as inadvertent trauma

Lessons I've learned

- Personal humility: I have to learn it, again and again.
- Clinical humility; **the expert** is sitting in front of me.
- Cultural humility; I cannot presume to know the forces that shape her decisions nor know how it is to have lived her life.
- Its time to stop telling and start asking.
- Then we have to stop talking and start listening. And learning.

Trauma & Violence Informed Care

SRHR of Women Living with HIV
WHO 1st Webinar
Sept 13 2017

Dr Neora Pick, MD, FRCPC

Medical Director, Oak Tree Clinic,
BC Women's Hospital & Health centre, Vancouver

Clinical Professor, Division of Infectious Diseases,

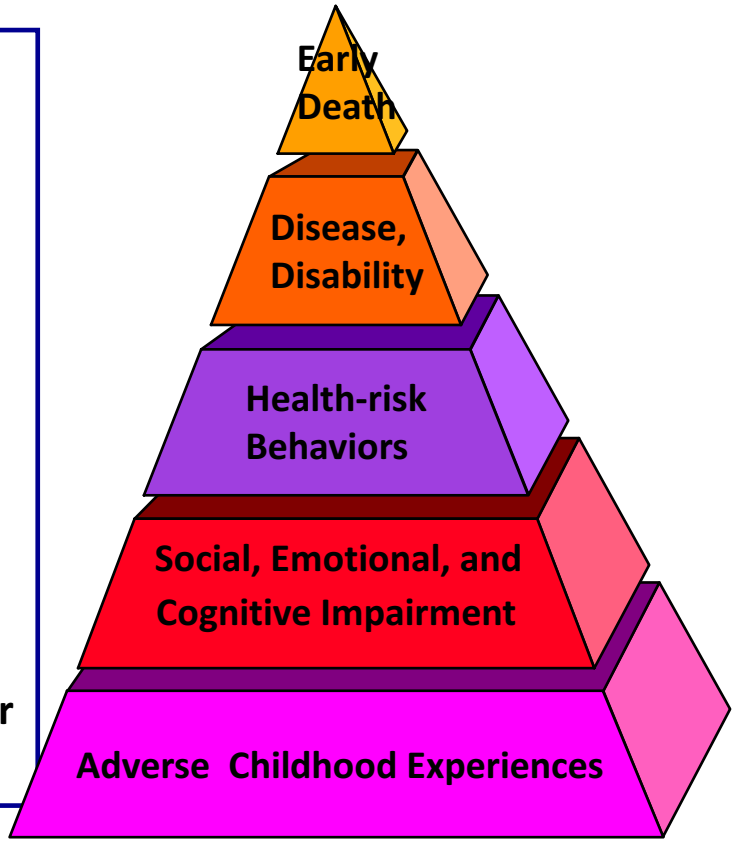
Department of Medicine, UBC

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Trauma/Violence and Health:
The Adverse Childhood experiences (ACE) Study

Note: 65% of women in CHIWOS experienced ACE! (Unpublished data) CHIWOS

- 17,000 patients completed surveys on 10 categories of childhood abuse, neglect & family dysfunction
- **Results: people who had abuse/neglect as children, had higher risk of high risk behavior: smoking, alcohol, substances use, & chronic diseases**
- **Experiences of interpersonal violence, racism/discrimination, can change neurobiological patterns that affect Mental/physical health, & economic vulnerability**
- **Conclusion: ACEs are common; are strong predictors of later health risks & disease**



Felitti VJ, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine. 1998 May;14(4):245-58.

The mechanisms by which Trauma affects health

- Still being studied..

1. Neuroendocrine, inflammatory and epigenetic changes that affect brain & body
2. Persistent anxiety, shame, stigma
3. **Profound effect on emotional regulation, self perception, relationship with others:**
   Adaptive but unhealthy coping behaviours

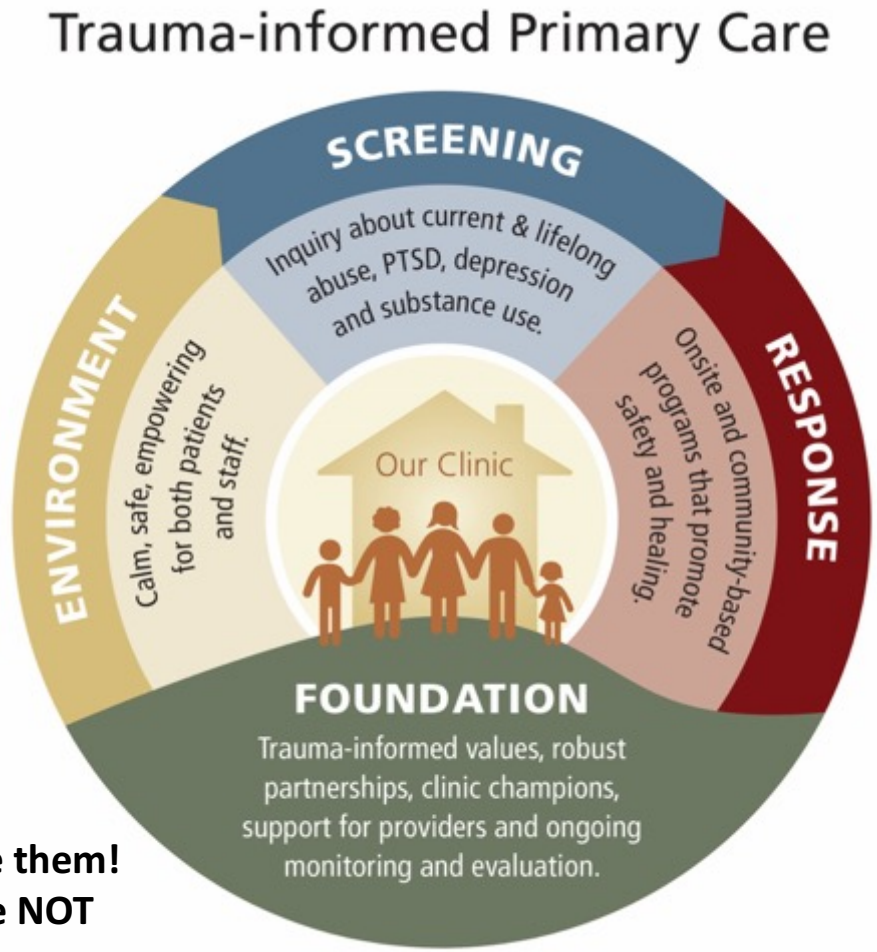
Machtinger, E. L., Cuca, Y. P., Khanna, N., Dawson Rose, C., & Kimberg, L. S. (2015). From Treatment to Healing: The Promise of Trauma-Informed Primary Care. Women's Health Issues, 25(3).

Impact of trauma on HIV-specific outcomes

- **Increased HIV incidence**
  - Maman et al, 2000, Jewkes et al., 2010
- **Faster disease progression**
- **Recent Trauma → 4x the rate of ART Failure**
  - Machtinger et al, 2012
- **More hospitalizations**
  - Pence BW et al., 2012,
  - Mugavero, MJ, et al., 2007
- **Twice the rate of death***
  - Weber, K., et al. 2012

Trauma-Key social determinate of health!

- **Aboriginal women >3X to experience IPV (Statistic Ca 2016)**
- **HIV diagnosis itself adds to their trauma**
- **HIV disclosure & pregnancy -very vulnerable times**
- **First clinical encounter** after HIV diagnosis **is critical for engagement in care**



Machtinger, E. L., Cuca, Y. P., Khanna, N., Dawson Rose, C., & Kimberg, L. S. (2015). From Treatment to Healing: The Promise of Trauma-Informed Primary Care. Women's Health Issues, 25(3).

- **Re: Screening:**
  Calgary, in **HIV clinic: screened 1721 pts**
  IPV prevalence- 46% W, 67% FN, but **only 22% were asked about IPV in any prior care***. **Missed opportunity?**

- **Screening should be linked to** time sensitive local **available services, that can address the abuse,** once violence is disclosed.

- **Believe them!**
- **You are NOT alone!**

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

*Raissi SE[1] et al. Implementing an intimate partner violence (IPV) screening protocol in HIV care.
AIDS Patient Care STDS. 2015 Mar;29(3):133-41.

VEGA-Violence Evidence Guidance Action

Canadian, not HIV specific

LISTEN	Listen closely, with empathy and without judging.
INQUIRE ABOUT NEEDS & CONCERNS	Assess and respond to specific needs and concerns – emotional, physical, social and practical (e.g., childcare).
VALIDATE	Show that you understand and believe. Assure them that they are not to blame.
ENHANCE SAFETY	Discuss a plan for protection in case further harm occurs.
SUPPORT	Support them by helping connect them to information, services and social support.

Bottom line: person's safety, autonomy, dignity, &well being should guide all decisions about how, when, and if to ask about IPV, & what to do next.

www.projectVEGA.ca

Oak Tree Clinic, Women's Centered HIV Care BCWH, Vancouver

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Women and Family-centered Care for:
- HIV+ women
- HIV+ and HIV-exposed children
- HIV+ partners
- Pregnancy and pre-conception counseling
- Research, advocacy and education

Interdisciplinary Team:
- Adult and Pediatric ID Specialists
- Obstetrics and Gynecology Specialists
- **Psychiatry Specialists-seeking safety groups**
- **Addictions and Trauma Counselor**
- Nurses and Nurse Practitioner
- Dietician
- Pharmacists
- **Social and Outreach Workers/nurse**
- **Peer support groups, 1 for FN women**

Since 1994:
- > 5500 patients
- 570 **pregnancies-NO transmission for women engaged in our care+ on HAART >4 weeks since 1997**
- >100 HIV+ children
- >500 HIV exposed children
- >650 patients actively engaged in care
- 2300 annual patient visits
- We provide **contraception counseling**, **Materna for pregnant women in need,**
- And **coordinate free formula for baby for 1 year**
- **Healthy snacks, child care provided (part time, by volunteers)**

Holistic care

604-875-2212 Toll Free (in BC):1-888-711-3030
www.bcwomens.ca/Services/HealthServices/OakTreeClinic/default.html

Oak Tree activities to address trauma

- TVIC was **identified as a gap, not standardized**
- **Trained on TVIC** –the **whole** team
- **Welcoming environment- Body mapping,** displayed in clinic corridor
- **Work with Indigenous liaison office BCWH, to make clinic culturally appropriate, add elder.** Also work with African groups
- **Avoid trauma triggers**: multiple providers in room, TV open with shootings, etc
- **Focus groups**, & a **comment box in waiting room- voice**
- **World aids day project: Portraits against stigma**, was therapeutic for women involved
- **Expanded peer support groups (4)**- in clinic, for Indigenous women, remote-for out of town women, PWN (closed)
- **Workshop on Equity & Enhancing care for Indigenous women**
- **Expanded outreach/case management& a female psychiatrist** to address trauma/PTSD, 1d/w

Do a Trauma & Cultural safety "walk Through"

In your setting

- Review the generic 'walk through' guidelines:
- Imagine a walk-though using a TVIC and Cultural Safety lens: in your chosen setting, ask:
  - What is a 'typical' client experience? What common trauma triggers might be encountered?
  - What is it like to enter the space?
  - How are safety and welcome promoted in the setting?
  - How is safety promoted in intake, screening and assessment?
  - How are client choice and empowerment promoted?
  - How is safety promoted, and violence and secondary trauma prevented for staff?
  - Don't use the words" you must"

https://ncsacw.samhsa.gov/files/trauma_walkthrough_rprt_508.pdf

https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

Create a

Welcoming Environment

***Ensure pts aware of clinic expectations=predictability. Unexpected change can be traumatic**

EQUIP Healthcare
Research to Equip Primary Healthcare for Equity

Version:
Oct 27 2016

Top 10 things Any Provider Can Do To

Support Women Experiencing Violence

WITH WOMEN:

1. **Listen to women and believe them –**
   "That sounds like a horrible experience"
2. **Affirm/validate –**
   "No one deserves…"
3. **Express concern –**
   "I am really concerned for your safety…"; "I am concerned that these headaches are connected to your circumstances at home…"
4. **Recognize strength –**
   "You have really survived a lot…"
5. **Offer collaborative safety planning –**
   "I'd like to help you make a safety plan…"; "Would it be OK if I got us some advice from…?"

See the women alone!
Opportunity to disclose IPV & other challenges

Believe them & in them!

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

YOURSELF:

6. Examine your own privileges and assumptions - e.g., education, position, power, wealth, experiences of violence

7. Learn about health effects of violence, danger assessment, safety planning

WITHIN YOUR ORGANIZATION:

8. Challenge language that objectifies, judges or blames –
   - Use "woman", "man", "people" – [instead of "battered woman", "abuser", "IDU", "at risk"];
   - Switch from "she doesn't want help" to "our help isn't meeting her needs";
   - Switch from "non-compliant patient" to "unsuitable care"

9. Anticipate and mitigate disempowering practices – e.g., evaluate routine instructions to undress; cancellation policies; waiting spaces

10. Contribute to organizational conditions to support good care – e.g., provider/patient ratios; policies, culture

Source: Varcoe, C. (2014). Interpersonal violence assessment. In A. J. Browne, J. MacDonald-Jenkins, & M. Luctkar-Flude (Eds.), Physical Examination and Health Assessment by C. Jarvis (Second Canadian Edition, pp. 120-137). Toronto: Elsevier.

EQUIP Healthcare
Research to Equip Primary Healthcare for Equity

CIHR IRSC

***Cultural safety-consider power relations:** political/social/economic/historical -realities of people **shape their behaviour (even tone/smell)**

***Be present!**

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Example of what it means in practice:

A woman comes for the 3rd time in a month to the clinic with vague abdominal pain. No organic cause found.

What often happens		TVIC
• Assume that she is "drug seeking", attention seeking, has underlying mental health problems • Redirect her to her primary care provider (dismiss her)	VS	• Question the root cause of her pain • Explore her safety and history of pain • Acknowledge her pain as real • Discuss non-narcotic alternatives for pain

BC WOMEN'S HOSPITAL+ HEALTH CENTRE

Prevent Secondary Vicarious Trauma in Staff

- **Secondary trauma can lead to Burnout: chronic fatigue, poor concentration, emotional detachment & physical illness.**
  - Makes Staff struggle to provide good care

- **Burnout may lead to staff turnover.**
  - Can create a negative loop, intensifying similar feelings in remaining employees.

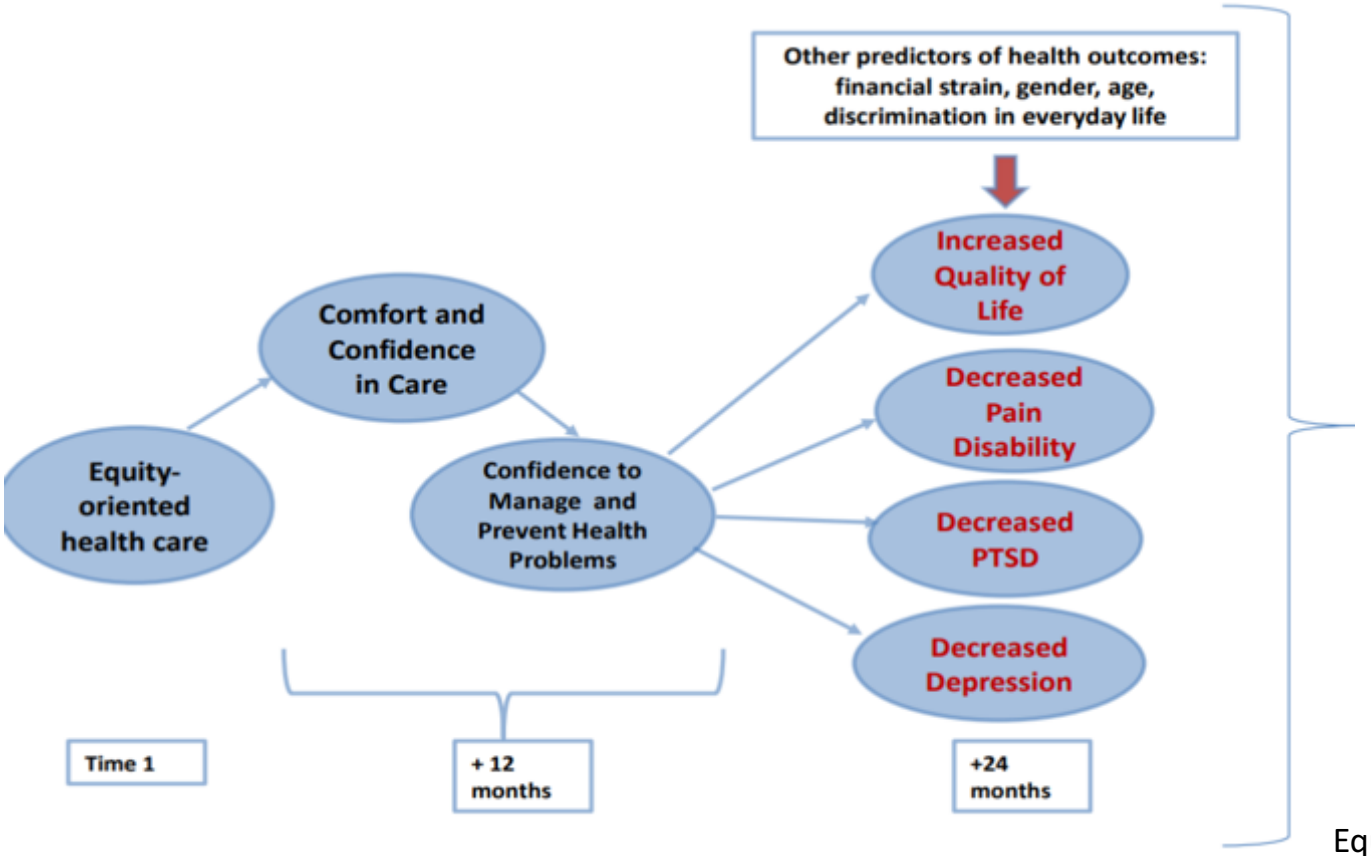
- **Preventing secondary trauma increases staff morale, improves function**, and **reduces cost (**of frequently hiring & training new employees)

- **Actions:**
  - Train on secondary traumatic stress
  - **Offer opportunities for staff to explore their own trauma** histories
  - **Create regular times to debrief** (on patients/crisis) to address their feelings & concerns.
  - **Encourage physical activity,** yoga, meditation, & counseling

Christopher Menschner, Strategies for Encouraging Staff Wellness.
https://www.chcs.org/media/ATC-Staff-Wellness-121316_FINAL.pdf

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Equity-oriented care (EOC) does influence patient outcomes!



Equip Health care study:
https://equiphealthcare.ca/

Steps for Trauma-Informed Organizational Practices:

1. Bring benefit of TVIC **to awareness of your organization's leadership/health authority/Government**
2. **Form a "Task Force"** for implementation of TVIC in your organization
3. **Educate *all* staff on the impact of trauma (all kinds) on health, & trauma symptoms**
4. **Create a framework for trauma sensitive care**-organizational & clinical culture change
5. Perform clinic "**walkabout from pts eyes**" with pts, & make **physical modifications** to the facility accordingly, **to provide welcoming & safe environment**
6. **Engage patients (**who experienced trauma) in organizational planning
7. **Develop protocols for response to IPV/racism/PTSD, to acute & lifelong trauma.**
8. **Prevent secondary traumatic stress in pts & staff**
9. **Advocate** for funding for **TVIC education & timely link to housing, MH/social services with gender lens, life skills & peer support groups (safe sharing=healing)**
9. Monitor and evaluate

Summary -Trauma aware care for women living with HIV

- **Violence/trauma damage women's Health, relationships with self, partners & medical system** BUT -People can heal,**cycles of violence can be broken. Providers have opportunity to create new patterns of health & well being for patients**
- **Implementation of TVIC across sites where WLWH access care, can be powerful strategy to address the widespread impact of individual & community trauma**
- **The model operates on empowerment/give control, emphasizing strength & resilience, minimize power imbalance**
- **Universal Trauma & Violence aware care, helps overcome barriers & is hopeful**: evidence-based approaches- help heal from past trauma, & realize their inherent power
- **In addition, addressing trauma is crucial for improved health outcomes, at client's pace**
- **It's the women's human right to live life free of threats and violence**
- **Women need Holistic care,** life is **multidimensional, change is a continuous** process

https://equiphealthcare.ca/toolkit/

*Chiwos, unpublished data, Angela Kaida, BC PI for Chiwos http://www.huffingtonpost.com/shannon-weber/women-hiv-and-trauma-towa_b_10489298.html

Minister of Indigenous Services *Jane Philpott* recently said:
"Physicians have moral responsibility to do more for
Canada's most vulnerable population.
Society grant MDs with power & privileges, & there is no better use of that power than to advocate on behalf of those who do not have the same opportunities "

Parliament Hill, Ottawa, May 31 2017

- We can not change the past, but **we can create a better health care system, that can holistically meet the care needs of women living with HIV in Canada with health equity & equality care,**

  to improve future health outcomes.

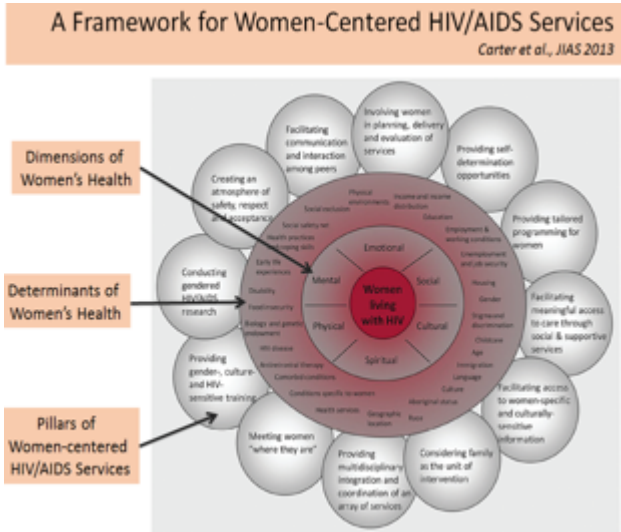
Campaign for Violence Prevention, WHO

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Resources:

- From treatment to healing: the promise of trauma-informed primary care. Machtinger EL et al. Womens Health Issues. 2015 May-Jun;25(3):193-7. doi: 10.1016/j.whi.2015.03.008.
- Future without violence: https://www.futureswithoutviolence.org/
- VictimLinkBC , and: www.projectVEGA.ca Equip: https://equiphealthcare.ca/

- Browne, A. J., Varcoe, C., Ford-Gilboe, M., & Wathen, N., on behalf of the EQUIP Research Team,. (2015). EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. *International Journal for Equity in Health, 14*(152). doi:10.1186/s12939-015-0271-y
- Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S., Krause, M., Tu, D., Godwin, O., Khan, K., & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: Evidence-based strategies from an ethnographic study. *BMC Health Services Research*, *16*(544). doi:
- Browne, A. J., Varcoe, C., Wong, S. T., Smye, V. L., Lavoie, J. G., Littlejohn, D., Tu, D., Godwin, O., Krause, M., Khan, K, Fridkin, A., Rodney, P., & Lennox, S. (2012). Closing the health equity gap: Evidence-based strategies for primary health care organizations. *International Journal for Equity in Health, 11*(59), 1-15. doi:10.1186/1475-9276-11-59
- Canadian Institute for Health Information. (2016). *Trends in income-related health inequalities in Canada: Technical report*. Canadian Institute of Health Information: Ottawa, ON. https://www.cihi.ca/en/factors-influencing-health/health-inequalities/trends-in-income-related-health-inequalities-in
- Farmer, P. (2013). Reimagining equity. In J. L. Weigel (Ed.), *To Repair the World: Paul Farmer Speaks to the Next Generation* (pp. 2-6). Berkeley and Los Angeles, CA: University of California Press.
- (VEGA), V. E. G. A. (2016). *Briefing note: Trauma- and violence-informed care*. Toronto, ON: VEGA.
- Wallace, B., Browne, A. J., Varcoe, C., Ford-Gilboe, M., Wathen, C. N., Long, P. M., & Parker, J. (2015). Self-reported oral health among a community sample of people experiencing social and health inequities: Implications for the primary health care sector *BMJ Open, 5*(e009519). doi: 10.1136/bmjopen-2015-009519
- Wyatt, R., Laderman, M., Botwinick, L., Mate, K., & Whittington, J. (2016). *Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper*. Institute for Health Improvement: Cambridge, Massachusetts. http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx



BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

What are trauma-aware values?

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

1. Safety, Health equity, with women as active participants in their care
2. Trust and Transparency. Be present.
3. Respect women's autonomy to make informed decisions about her health, Share info & Collaborate
4. Empowerment: Voice and Choice
5. Peer support
6. Acknowledge Systemic barriers including racism, colonization, power imbalance, sensitively assess **Violence** & **poverty**
7. Respond to women's needs in holistic, cultural sensitive approach

- *SAMHSA's Concept of Trauma and Guidance for a Trauma-informed Approach. 2014* http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf.
- WHO SRHR Exec summary 28/3/2017

Thank you

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

- Women living with HIV, who teach us so much about resilience, survival, and life
- Colleen Varcoe, Professor, UBC School of Nursing
- Annette Brown, Professor, UBC School of Nursing
- Edward Machtinger, Professor of Medicine and Director of the Women's HIV Program at the University of California, San Francisco (UCSF).
- Oak Tree Clinic Staff, BCWH committed leadership, PHSA, Vancouver
- WHO-Dr. Manjulaa Narasimhan
- Trauma aware team members on this webinar

Contact: Neora Pick
npick@cw.bc.ca
Tel: 604-875-2274

Leah Marie Dorian- Métis **artist** raised in Saskatchewan (**Canada**)
A woman surrounds herself with the loving radiance of Grandfather Sun.
In First Nations teachings, Grandfather **Sun is a great healer** and can help us bring balance in our lives

Trauma and Violence Aware Care Meaningful Involvement of Women Living with HIV (MIWA)

Tracey Conway, CPPN Co-chair

Trauma Aware Care

September 8 2017

Tracey.Conway@cppnrcps.ca

Meaningful Involvement/Engagement of Women Living with HIV (MIWA)

- Comes from GIPA Greater Inclusion of People Living with HIV

"There is no substitute for direct experience, which can be considered a kind of expertise if accompanied by the ability to communicate well." GIPA requires making space for individuals to:

1. "Use their experience of living with or being affected by HIV/AIDS in the greater response to the epidemic"
2. give a human face and voice to the epidemic in the minds of people not directly touched by it.
3. Be involved in all levels of decision making and participation within organizations and projects.(UNAIDS, 1999)

Key Points

- Inclusion at all levels of project including conception, implementation and evaluation
- Reciprocal mentoring and capacity building, respect knowledge and skills that are present, while maintaining awareness of power imbalances; acknowledge community knowledge, wisdom, especially expertise in their own lives.
- Ensure community represents populations being served and has expertise.
- Compensation: fair market value for work: value time in the same way as time of other researchers is valued; respect time commitment; clearly establish guidelines, take into consideration how payments will affect other income sources. Ensure required resources are available
- Important that this work belongs to the community:

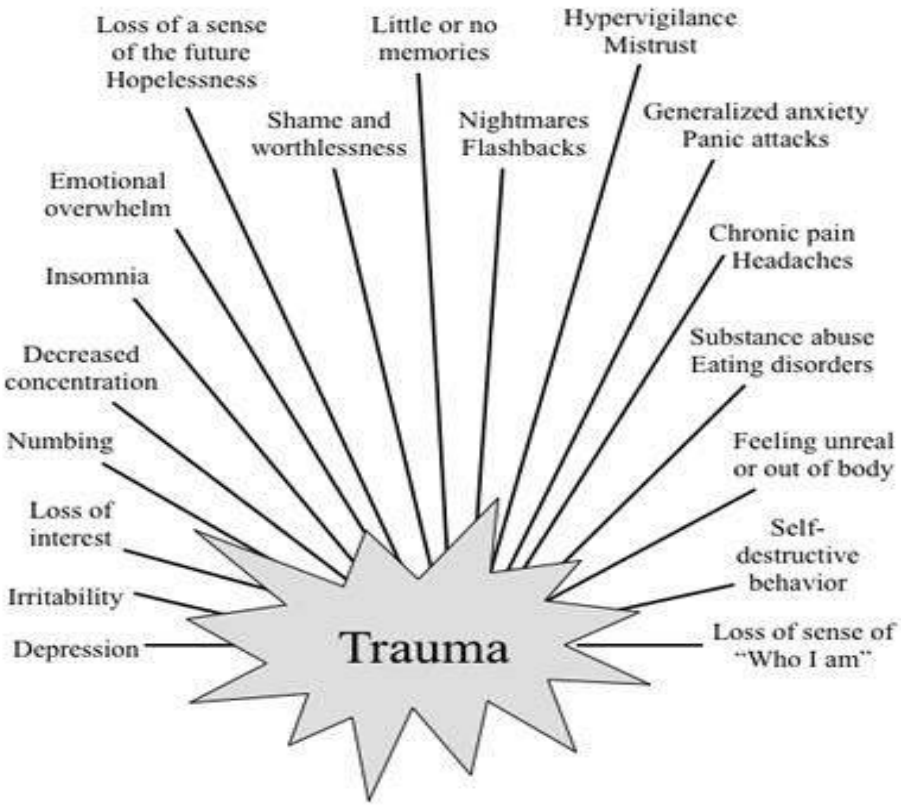
NOTHING ABOUT US WITHOUT US

www.cppnrcps.ca
cppnrcps@cppnrcps.ca

Barriers

- In many environments, stigma and fear impact the ability of WLWH to engage
- A lack of economic and social power experienced by many WLWHs
- A lack of education, adequate resourcing and skills building for MIWA to have better impact
- Tokenization
- Lack of experience and adequate process
- Lack of resources
- Not recognizing power imbalances

Women Living with HIV and Trauma



"Trauma survivors have symptoms instead of memories" [Harvey, 1990]

Adapted from Bremner & Marmer, 1998

Copyright 2007 Janina Fisher, Ph.D.

Keep in Mind

- Trauma affects vast majority of WLWH 80% (data from CHIWOS)
- Requires an individualized multidimensional and holistic approach
- Meet the person where they are at
- Recognize that women may be re-traumatized and triggers
- Peers or other women living with HIV may play a key role

Trauma and Violence Aware Care: Immigrant, Refugee and Non-status (IRN) Women Living with HIV

Wangari Tharao
Director, Research and Programs
Women's Health in Women's Hands CHC,
Toronto, Ontario, Canada

Canadian Webinar Series on Implementing the WHO Guidelines on Sexual and Reproductive Health and Rights for Women Living with HIV
September 13th, 2017

Mandate: Women's Health in Women's Hands CHC

- To provide primary healthcare services to racialized women from the African, Black, Caribbean, Latin American and South Asian communities in Toronto and surrounding municipalities.
- We work from an inclusive feminist, pro-choice, anti-racist, anti-oppression, and multilingual participatory framework
- Multidisciplinary teams of:
  - Clinicians, nurse practitioners, registered/practical nurses, therapists, social workers, health promoters/educators, community health workers, dieticians, chiropodist, etc.
  - A dedicated team of research coordinators and researchers within academic and community-based settings
- We address issue of access to healthcare using an intersectional lens and within the determinants of health that are relevant to racialized women:
  - gender, gender identity, race, class, violence, sexual orientation, religion, culture, language, disability, immigration status and socio-economic circumstances.

Trauma and Violence Aware Care:

- What is the reality of IRN women's lives?
- What factors shape this reality?
- How does their reality impact access, navigation and engagement with health services?
- How can their reality be mitigated to improve and facilitate?

Digital Story: "A letter to my old self"

" I am a twenty-five year old woman…... I migrated to Canada in 2007. I know I struggle with **sexual abuse, physical abuse, mental abuse, self-harm, neglect, racism, self-identity, sexuality**, and **trust**. All these things took part in my life before I was the age of fourteen. I still struggle with these memories. They hated me because of my **colour**. They hurt me because I **am a woman** and had **no choice**. They **ridiculed me** because of who I love **(lesbian). I hurt me** because I didn't know better. **I hurt me** because I couldn't see better….. At one point **I turned to alcohol, marijuana, and violence**, but it never helped just made everything worst. I am wrapped up and **consumed by all this hate I feel**. I still sometimes **feel hopeless and stuck**, so now I rationalize my darkest fears and **try to let them go**. **I won't be lost** forever is what I say"

Digital Story: "Traditions"

"A young East African **girl born and raised in Canada** goes to her mother's land for the first time at the **ripe age of nine**, excited yet weary of the unknown, at least unknown to her. She was already packing and can't wait to get on that plane weeks from now. Once she gets off that plane and her feet touch the sand, **she is met with roars of excitement upon her arrival**. She feels like a real live princess. ….. She had never heard about **female genital mutilation** until then, all the people that loved her, her aunties, caregivers, her grandmother they did this to her. These are the people that showed her love yet the put her in danger. They **took away the girl's right to her body and sexualized** her even though she was only a child. They claimed it was **to keep tradition alive**, but not all traditions need to live".

Determinants of Health

" Because of **poverty** you have **housing issues**, then you have **lack of access to adequate nutrition**. You have **lack of transport**, you know, increased costs going **back and forth between doctors and pharmacists**. You know, people making **decisions** about whether they have enough **money for milk** or to **take the bus** to see the doctor – WCBR Project.

Fragmentation of Lives' and Services:

- Fragmentation of self:

  "when you seek HIV services, you are a women living with HIV. When you go to lesbian (LGBTQ) spaces, you are a lesbian….. When you go to community organizations/ASOs, you are a Black woman….. When will I be a whole person?" – WCBR project.

- Fragmented services:
  - Limited "one stop shop" services for women living with HIV in Canada
  - In Ontario, HIV care is delivered mostly in HIV clinics
    - Were originally formed to serve gay men
    - Never shifted based on shift in epidemic to include more diverse populations e.g. women
  - Need to create a model that's based on NEEDS of women living with HIV

Creating a Trauma and Violence Aware Model (1): How should it look like???

- Framed within an Anti racism/anti oppression (AR/AO) that recognizes:
  - Intersecting dimensions of oppression
  - effects of power and privilege and its impact/burden on women who have experienced multiple traumas and violence
- Involve partnerships and working with allies to facilitate equity and self determination
- Integrate the relevant determinants of health
- Grounded in community based, participatory action and leadership
- Promote active participation of IRN in decision making in their healthcare and healthcare delivery
- Recognize that IRN women live their lives in multiple transnational "spaces" which impact on their day to day realities.
- Recognize IRN women's rights and the need to be treated with respect and dignity

Creating Trauma and Violence Aware Model (2): How should it look like??

- Grounded on sound research that is:
  - Ethical and respectful
  - addresses specific needs of IRN women
  - Fosters autonomy, efficacy and self determination
- Understand how political and economic forces impact the health and well-being of IRN women
- Link service delivery to research and policy as a continuum

Contact information:
Email address:
Wangari@whiwh.com
Telephone No: 416 263 4870

Canadian Aboriginal AIDS Network

Discussion

Reminder:
Please type your questions into the text box at the bottom of your screen.

If your question does not get answered, please check back on the uploaded link (provided below). We will review and answer any remaining questions, and post alongside the recorded webinar.

The Webinar will be posted in the HRP Video Library:
https://www.youtube.com/user/MediaHRP

IBP video library:
https://webinar.com/channel/965084607443925509

Next Steps

- Developing a **Canadian Action Plan** to address the Sexual and Reproductive Health and Rights for Women living with HIV, including priorities highlighted from the Trauma and Violence Aware Care webinar.

Webinar 2: Save the Date!

Supporting Safe HIV Disclosure: Canadian Webinar Series on Implementing the WHO Guidelines on Sexual and Reproductive Health and Rights for Women Living with HIV

Thursday, November 16th 2017, 9-10:30am PST / 10-11:30am MST /12-1:30pm EST / 6-7:30pm Geneva

Thank you!

For more information about the Canadian Webinar Series, please contact:

Rebecca Gormley (BC CHIWOS Coordinator)

Phone: 1-855-506-8615 option 1 (toll-free)

Email: rgormley@cfenet.ubc.ca