
Michele Rountree, The University of Texas at Austin
Marsha Zibalese-Crawford, Ariel University
Meredith Bagwell

Women who have experienced intimate partner violence (IPV) are at a heightened risk for HIV infection, and HIV seropositive women are at risk for subsequent risk for IPV and re-infection when their HIV status is disclosed. IPV is defined as physical, sexual, or psychological harm by a current, former partner or spouse (Saltzman, Fanslow, McMahon, Shelley, 2002). African-American women are vastly overrepresented in their experiences of these two major public health concerns. Twice as many African-American women as white women in abusive relationships are killed by their intimate partner, and African-American women’s partners who are abusive are more likely to cause them acute injuries and use weapons against them (Lee, Thompson & Mechanic, 2002). Compared with women of other races and ethnicities, African-American women had the highest rates of new HIV infections between 1999 and 2004 (Espinoza et al., 2007).

A body of scholarship highlights the association between IPV and HIV where women who have experienced IPV are at greater risk for infection (El-Bassel, Gilbert, Krishman, Schilling, Gaeta, Purpura et al., 1998; Wingood, DiClemente, & Raj, 2000; Wu, El-Bassel, Witte, Gilbert, & Chang, 2003, Gielen, Ghandour, Burke, Mahoney, McDonnell, 2007). Among a nationally representative sample of 13,928 women, 11.8% of HIV cases were linked to IPV, and women who experienced IPV were 3 times more likely to report HIV infection than those who had not (Sareen, Pagura, & Grant, 2009). IPV is associated with a host of sexual risk factors such as unprotected sex, higher rates of sexually transmitted diseases, multiple sexual
partners, having a sexually risky partner, drug and alcohol use, trading sex for drugs or money, childhood sexual abuse, forced sex, and inability to negotiate condom use (El-Bassel, Witte, Wada, Gilbert, & Wallace, 2001; Johnson, Cunningham-Williams, & Cottler, 2003; Raj, Santana, La Marche, Amaro, Cranston, Silverman, 2006; Ramos, Carlson, McNutt, 2004).

Among a sample of 200 African-American women, Josephs and Abel (2009) utilized structural equation modeling to identify a strong positive correlation between frequency of physical abuse and sexual coercion. They also established a moderate correlation between sexual coercion and being afraid to request condom use with an intimate partner. Although research has provided us with information on IPV and on HIV/AIDS, too little is known about the pathways that link them from the lived experiences of African-American women in particular. To build on current research, these pathways were examined in the current study by analyzing data from a series of focus group sessions conducted in two different parts of the country of African-American survivors of IPV (n=9) and seropositive African-American women (n=17).

Scholars report power differentials between men and women (Amaro & Raj, 2000; Bowleg, Belgrave, & Reisen, 2000; Harvey & Bird, 2004) can lead to male-perpetrated IPV and unequal sexual negotiation in which men control condom use (Tjaden & Thoennes, 2000). Gender inequality is well documented as a risk for HIV infection (Kyomugisha, 2006; Türmen, 2003). According to Jarama, Belgrave, Bradford, Young, and Honnold (2007), “Some African-American women may have more difficulty refusing sex, negotiating condom use, deciding when to have sex and influencing their sexual practices than their white counterparts because of their relational orientation, power differentials and other structural factors (e.g., incarceration rates, male-female sex ratio)” (page 308). In this way, IPV and lack of relational power lead to HIV risk for women in violent relationships.
Correspondingly, when considering the relationship between HIV and IPV, women living with HIV/AIDS may be at risk for IPV. The possibility that HIV disclosure could lead to subsequent abuse is disconcerting, because disclosure is necessary in order to obtain health system and personal support. In one study of 310 women with HIV positive diagnoses, 45% reported experiencing emotional, physical or sexual abuse at some point after their diagnosis, with 4% reporting physical violence immediately after a disclosure event (Gielen, McDonnell, Burke, & O’Campo, 2000). Making causal inferences between HIV infection and IPV experience is difficult because (1) definitions of IPV vary considerably across studies and (2) there is no data to document the experience of IPV and timing of HIV diagnosis (Gielen, Ghandour, Burke, Mahoney and McDonnell, 2007). However, taken together, studies illustrate how IPV can be both a risk factor for HIV and how disclosure of seropositive status can lead to subsequent abuse and re-infection.

Given the contextually specific risk factors and disproportionate infection rates among African-American women, there is need for more interventions to increase risk reduction among this population (Prather et al., 2006). Among the HIV/AIDS interventions recommended by the Centers for Disease Control and Prevention, several do target African-American females. SISTA, SiHLE, Sisters Saving Sisters are specific for adolescent girls, another targets women who are already pregnant (Centering Pregnancy Plus), HIV- positive (WiLLOW) or women diagnosed with another sexually transmitted infection (SAFE). While each of these interventions may have important components specifically relevant to gender and race there is an opportunity and need for further research among this population, particularly as it relates risk reduction within abusive relationships and investigation into social and contextual factors that may serve as protective factors from infection. The end aim of such efforts would be to design a culturally
and contextually relevant HIV prevention intervention for this population. This research in particular supports the CDC's *Heightened National Response to the HIV/AIDS Crisis among African-Americans (HNR)* effort in launching comprehensive HIV programs directed towards fighting the epidemic in African-American communities (CDC, 2008).

This study will pay particular attention to the personal and partner characteristics that may elevate risk factors for sexual risk, the aspects of culture that serve as protective or risk factors in the women’s lives, living with an HIV diagnosis, and intervention strategies.

Methodology

Institutional Review Board approval was obtained to conduct the study. Given the overall goals of unraveling meaning and contextualizing the experiences of a marginalized population, we determined that a qualitative design using focus group methodology would be most appropriate. Focus groups have become a popular method of data collection in conducting research with minority populations (Kress & Shoffner, 2007). In addition, focus groups were chosen for data collection for this study since feminist researchers argue that focus groups are especially helpful in reducing imbalances of power between the researcher and those being researched (Montell, 1999) whereby focus groups offer social contexts for meaning making and allow for balance of power between research and research participants (Montell, 1999) in that this method involves “collective consciousness work” (Fine, 1992) to be undertaken by participants rather than simply gathering data from them. Relevant to this study’s line inquiry feminist researchers argue for more contextualized methods to be used in research on intimate violence where power, gender and other systems of domination are understood as setting the conditions for violence and contributing to a perpetrator’s choice to use violence against his/her
partner (Renzetti, 1995; Yllo, 1993). In this study we sought to maximize discussion, focus
groups are particularly useful in gathering data through dialogue and active interaction where
power differentials may exist (Kitzinger, 1994).

Setting & Sample

African-American Survivors of Abuse. Data collection was conducted on the premises of
a domestic violence shelter located in the southern region of the United States. A convenience
sample of African-American, female residents of the shelter or transitional living facility
(n=9) participated. Participants had been in the shelter for up to 3 months or in the transitional
living facility between 3 months and 1 ½ years. The participants’ average age was 35.7
(SD=10.4), four (44.4%) had a high school diploma, and one (11.1%) had a college degree. As to
martial status, most were single (n=5; 56%). All of the women reported having children (average
of 2.7 children), one third of the participants (n=3; 33.3%) had no income, a third (n=3; 33.3%)
had a monthly income less than $1000, and no participants had a monthly income of over
$2,000.

Purposive sampling was used to identify participants who met the following criterion:
African-American women who 1) were over the age of eighteen and 2) had experienced
rape/sexual abuse or had unwillingly had sex with a male partner within their relationship.
Recruitment included two strategies: either participants were identified by the shelter staff or
participants who were interested by posted flyers contacted the principal investigator directly.
All participants were provided an overview of the study, a guarantee of confidentiality, and a
$25.00 grocery store gift certificate at the end of the focus group as an incentive to participate.
Declining to participate in the study did not affect services received from the shelter. Socio-
demographic information was collected. Guiding research questions for focus groups in both
parts of the country included inquiry into HIV/AIDS knowledge, transmission, and risk reduction behavioral strategies, influences of sexual abuse or rape on risk for HIV infection, and participants' perspectives on developing contextually and culturally relevant HIV/AIDS risk reduction intervention for African-American female IPV survivors. The audio recorded focus group session conducted on the premises of the domestic violence shelter lasted approximately 90 minutes and was co-facilitated by an African American clinician.

**Seropositive African-American Women.** Focus groups were conducted of African American women (n=17) living with HIV/AIDS in an urban eastern part of the U.S. Convenience sampling was used where the focus group sample participated in the sessions after an event at a local AIDS service organization. Participants were provided $25 as compensation for their time, plus public transportation travel funds.

Three focus groups with seventeen HIV-positive African American women were conducted by two African-American clinicians who facilitating each session. Mean age of the samples was 31.4. Seventy-five percent had completed high school, and 25% were employed. Most (75%) received welfare/TANF benefits and 80% had children. Regarding relationships, 17% were married, 27% were divorced, and 56% were single or never been married. About 17% of participants were not in a relationship; 57% had been in a relationship between one to five years and 36% had been in a relationship for six years or more. About 25% of the participants lived with the person with whom they are in a relationship. One-third (33%) of the participants know the HIV status of their current partner, but more than half (56%) said that their partner knows their HIV status. The majority have not been pregnant since their diagnosis, but five participants have been pregnant and only one of the children is HIV positive. Two-thirds (66%)
had not used condoms with casual partners before their diagnosis, and 50% used condoms with primary partners since diagnosis.

Each audio-taped focus group session lasted approximately 60 to 90 minutes. Focus groups were audio-taped in order to be transcribed word-for-word for coding purposes. Facilitators asked participants to respond to all questions; at the end of the session, facilitators provided a verbal summary of the discussion, allowing participants to respond regarding the validity of the summary. Last, the rationale for conducting focus groups in two areas of the country was the investigators having strong, positive relationships with community agencies within their respective regions where recruitment for the study would not be a challenge. In addition the prevalence rates of IPV and HIV/AIDS among this population in these regions would provide insight to the line or research inquiry.

**Theoretical Approach**

Grounded theory “seeks to inductively distil issues of importance to specific groups of people, creating meaning through analysis and the modeling of theory (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1998; Ghezeljeh & Emami, 2009). We selected grounded theory because it is appropriate for “researchers who are interested in designing interventions to support people engaged in the social processes explained by the theory” (Starks & Trinidad, 2007, p.1377). Moreover, Auerback, Salick and Fine (2006) found grounded theory to be beneficial in developing treatment strategies for clients who have experienced multicontextual trauma, while Teram, Schachter, and Stalker (2005) found that integrating grounded theory and participatory action research “can empower clients to inform professional practice,” when working with adult sexual assault survivors (p. 1129).
Data Analysis

Notes from all of the focus groups were transcribed into text files for analysis. In order to ensure consistency, each file was compared, proofed and validated by the researchers. Using the qualitative software data Atlas.ti, pattern coding procedure and analysis was conducted by three coders to identify emergent themes and patterns (Miles & Huberman, 1994). Data was initially coded by members of the research team to identify first-order and second-order themes that emerged for the focus groups. A third member of the research team reviewed the initial transcripts and analysis, bringing a fresh perspective and confirming and refining the analysis by using the procedure of directed content analysis. Because traditional standards for reliability and validity do not apply to qualitative studies, other strategies are available (Padgett, 1998, p. 95). In particular strategies for triangulating the data were employed such as conducting a post-group questionnaire to confirm themes identified in the focus group, and holding debriefing sessions among facilitators. To maximize credibility, reliability, and quality in analysis and interpretation (Padgett, 1998), we used multiple coders, kept an audit trail, debriefed with colleagues, and also explored negative cases. The post-group questionnaire offered women the opportunity to add any additional thoughts in writing in responses to questions guiding the focus group sessions.

Results

Overarching themes were identified across focus groups of women who had experienced IPV and those with an HIV seropositive status. This discussion highlights the themes that overlapped for focus group participants regardless of seropositive status. In this section, we summarize these major themes, weaving in the women’s own words to best capture their meaning. Quotes by African American survivors of abuse are designated by “AA survivor of abuse” and seropositive focus group participants’ quotes are delineated by “seropositive AA
The primary themes that emerged revolved around women’s inability to practice known HIV prevention techniques with their intimate partners, a disconnect between ideal situations and lived experiences, the influence of culture, and intervention strategies to protect oneself from HIV.

**IPV as HIV Risk: Inability to Practice Known HIV Prevention Techniques with Intimate Partners**

Overall, participants across focus groups were highly aware of beliefs, knowledge, and practices of HIV/AIDS prevention. They knew how HIV is transmitted, specifically through sex and sharing needles. They clearly understood prevention methods of abstinence, condom use, and/or monogamy with a trusted partner. However, despite their knowledge and belief that practicing safe sex should be a priority, many participants had not been able to engage in protective practices due to abuse and personal and partner characteristics.

**Personal and Partner Characteristics Related to HIV Risk.** Personal characteristics that influenced the clients’ sexual risk included mental illness, loneliness, infidelity, no support, multiple abusive partners, and addiction problems. These characteristics were often interrelated. The participants specifically focused on their drinking and drug use, which served as an escape from abuse, helping numb out their depression and low self-esteem. Alcohol and drugs provided a way to “fade out” and “deal with being there with that person,” *(AA Survivor of Abuse)*. When they were using drugs they had no motivation to live: “[Alcohol or drugs] might as well try to kill me. You know what I’m saying? Because you’re killing me anyway,” *(AA Survivor of Abuse)*. This sentiment reflected the larger problem that there was not much incentive to protect themselves from any negative health effects—be it HIV infection or addiction—because they believed they had no reason to do so.
The participants’ partners’ characteristics compounded their sexual HIV risk. Partner characteristics included addiction problems, mental illness, controlling behaviors, sexual perpetration, and physical abuse. Just as the participants own drinking and drug was a major risk factor, so was their partners’. However, with their partners, the drug use was related to infidelity, risky sex outside of the committed partnership, and rape within the relationship. Even when drugs and alcohol were not involved, participants were unable to assert themselves sexually in their intimate relationships because of their partners’ controlling behaviors, sexual perpetration, and physical abuse. The participants’ powerlessness manifested itself through an inability to make decisions regarding their sexuality, from incapacity to negotiate condom use to coerced or forced sex:

I was forced to have sex when I didn’t want to, even when I was pregnant. And the thing is, I was so scared because my biggest fear was, “Okay, I’m gonna end up with something. The baby’s gonna end up with somethin,” you know? And no matter how hard I tried to protect myself, it was just, it was like I had no protection, and that was the big issue for me,” (AA Survivor of Abuse).

Even if the women had not been forced to have sex by their abusive partners, many of the women harbored suspicions that their partners were involved in multiple sexual relationships. The physical abuse in itself “raises a lot of flags, period,” and provoke the question: “who else is he doin’ outside our relationship?” (AA Survivor of Abuse). Among the focus groups of HIV seropositive women, these suspicions were often confirmed with his positive diagnosis of HIV. One stated, “I don’t want to be back with him, but he [just] found out he has it, which I think is a lie. I think he knew a long time, because women have come up to me and told me…” Another
expressed, “When I found out my partner was HIV positive, I was mad and wanted to kill him. I wanted to pack up and leave him.”

Disconnect Between Ideal Situations and Reality of Living with Abuse. The participants across focus groups articulated a belief that they deserved to be treated well. They recognized characteristics of ideal, healthy relationships and verbally expressed that women should not settle for less. For example, there was agreement among many that they would not have sex with a partner if he refused to get tested or was not willing to participate in a respectful, honest conversation about safe sex practices. At the same time, however, many participants recounted forced sex, infidelity, or multiple abuse histories. Thus, they demonstrated a separation between their beliefs and knowledge about healthy relationships and safe sexual decision-making and their ability to integrate these within the context of their lived experiences. This is clearly illustrated by one participant when she stated “the word no should be sufficient. Just say, you know, no… when it’s possible for you to have a conversation with somebody, no should be sufficient.” The significance of this statement lies in the fact that her belief in a woman’s ability to say no is in conflicts with the reality of her personal experiences:

You just have to get out, you know, because a lot of times the guy doesn’t give you a choice of whether to say yes or no… I said no, so I get beat up and I get raped anyway. ... So it’s just leave. Get out, you know, you’ve got to go away,” (AA Survivor of Abuse).

This participant can describe and recognize characteristics of a healthy relationship, specifically that a woman should have sexual self-efficacy; however, having knowledge and
having the power to act on it are two different things. In the end, because of her partner’s abusive behaviors, the only way for her to have control in the relationship was to leave it.

Many participants believed that practicing safe sex was a priority yet expressed an inability to engage in safe-sex practices with their partners:

He kept saying he wasn’t going to use a condom, but he was going to take it one way or another, and had me pinned on the bed. But my brother came in and stopped him. *Seropositive AA Survivor*

The participants’ stories illustrate a gap between what they believed relationships should look like and what their experiences had been. They knew the importance of HIV prevention, HIV positive serostatus disclosure, and healthy, communicative relationships characterized by mutual respect. However, their lives were shaped by experiences with abusive partners and an inability to practice safe sex. The missing link, then, appears to be in how to translate the possible—what should be—into the reality of their lives.

*Culture Shaping Sexual Risk and IPV*

The prevalence of HIV/AIDS among the African-American community was reflected in the way the AIDS epidemic hit close to home for many of the African-American survivors of abuse. Typically, a friend, family member, classmate, or intimate partner that they had known had been diagnosed with or died from HIV/AIDS. However, regardless of this personal experience with the disease, discussions indicated a perpetual problem of silence in the African-American community surrounding HIV/AIDS: “A lot of African-Americans are naïve of the fact [of their HIV risk]. And a lot of them are in denial… sometimes they don’t look past their heart, you know . . . and then they wind up HIV positive,” *(AA Survivor of Abuse)*. This silence is illustrated in that several participants did not find out about AIDS until they were tested during
pregnancy, at which point they had been having unprotected vaginal intercourse. Others could not talk to their immediate family about it. For example, one participant shared that, upon asking her mom, she was told that AIDS happens to “dirty girls;” this participant educated herself about HIV/AIDS by asking the school librarian for information and resources (*AA Survivor of Abuse*).

Institutional exclusion shaped the participants’ HIV risk and diagnoses. Examples included a lack of accessible or culturally tailored information about where to go for support and safety and deficiency in organization advertising “that start with black women in general,” (*AA Survivor of Abuse*). Additionally, culturally-based, traditional gender norms and racial stereotypes emerged as participants relayed their experiences. First, participants seemed hesitant to disclose situations where they had little to no sexual self-efficacy because of African-American women having to be strong and capable of self-defense:

> I been married to my husband for six years, and I think I been, I been through it with him jumpin’ on me and I think I been surviving because I fight back. I’m 4’11” and he’s 6’2”, but there’s no way he’s gonna jump on me. *AA Survivor of Abuse*

African-American men, on the other hand, were described as being possessive as well as “hot-headed” by nature:

> And then, there it goes. The argument, and then, once the argument goes farther, a fight. Black men in general, they hot-headed. Bottom line. Hot-headed. *AA Survivor of Abuse*

The combination of these gendered behaviors lead to a cycle where it is somewhat normative for men to be abusive while the women repair the damage, hold the relationship together, and endure the hardship—fighting back and protecting themselves.

Participants discussed a cultural norm of not talking about problems outside of the family:
I want to report as far as relationships counseling. I mean…people fear it, you know, we’re not used to it. Sitting down talking to somebody about our problems. That’s not normal for us as Black people. It’s not what we’re used to. *AA Survivor of Abuse*

Some participants stated that religion may have a positive effect on risk behavior. A “return to faith” conversation with a new lease on life may decrease risk behaviors. Women may stop using drugs, for example, and become more capable of responsible decision making. It was not uncommon for a woman in a group to declare, “I’ve always been in church,” or “I’ve always had God in my life.” One woman added, “I just ask God a lot more questions now [that I have the virus].” In relation to IPV, a religious belief of protection and guidance from a higher power greater than her partner’s abuse transcended her current reality to one of hope. Sometimes her religious belief of staying in a relationship for better or worse kept her in the relationship while, at other times, her belief system provided her the strength to leave.

*Disclosure of HIV Diagnosis*

The choice to disclose was often a drawn-out process, largely determined by factors in the individual’s environment—for example, the degree to which their basic needs were being met and the likelihood of injury or death as a result of a partner discovering their HIV status. The participants often found that disclosure elicits a variety of reactions from others, often negative, including pity, anger, irrational fears of contagion, and rejection. One stated simply, “My family changed [when I told them my HIV status]. They don’t come around [me],” *(Seropositive Survivor of Abuse)*

Given these challenges associated with disclosure, the most common strategy the participants employed was concealing their status. One participant described the reason for her fear of disclosure, “I’m working on [disclosure to my partner] – we’ve been together for two
years now. You know, when you tell somebody [disclose], they leave out of your life just like that!” (Serpositive Survivor of Abuse). Another spoke of the emotional trauma that can occur if you disclose: “It’s hard for someone to keep throwing it up in your face everyday [that you are HIV-positive.]” (Serpositive Survivor of Abuse).

Women who are in a relationship upon diagnosis seldom receive positive reactions from their partners when they disclose.

When I first found out [that I was HIV-positive], he was there at the clinic and I was pregnant. He wanted to know [why] the doctors wanted to see me. At the same time, [the doctor] told me I had [HIV] and I caught that from him. And it is no saying [at home] that I caught the virus from him. And he took it out on me, and we got into physical fights . . . It’s like, why are you taking it out on me? We both found out at the same time, so it’s not completely my fault! (Serpositive Survivor of Abuse)

Yet, not all disclosure ended badly. Most often when a woman reported that her partner did not react with abuse, he was also a person who had been living with HIV/AIDS for some time.

My partner—I told him I am HIV-positive . . . at least one month into the relationship. And he wanted to know, “How did I get it?” . . . I told him I got it from my son[’s] father, and he was okay with it. He didn’t treat me [any] different. We actually became closer after I told him that. (Serpositive Survivor of Abuse)

If a woman understands that disclosure may be the immediate cause of the end of an intimate relationship, and feels strongly that disclosure is the best way for her to cope with her
HIV, then she will be ready to pay the price. Once a woman decides to use disclosure as a coping strategy, there are a number of ways of disclosing to a partner. Participants in abusive relationships often knew the boundaries set for them and employed creative means to disclose while simultaneously protecting themselves. For example, some woman informed their partners without talking about it—in nonverbal ways. For some, nonverbal disclosure reduces the risk of confrontation by giving the partner time to think, rather than being forced to react to a verbal confession. This is method is facilitated if the partner himself is living with HIV/AIDS. One woman in the study communicated her status by placing her HIV medications next to his. More mature male partners may not listen to her disclosure or even wish to talk about it as he may not want to know.

If the partner is violent, the woman may choose to disclose in her social worker’s office or when people she trusts are around. In the first case, the caseworker may suggest bringing the partner to the office, though this can also be a difficult and complicated endeavor. The second case, however—that of disclosing when friends or family members are around—involves much less control over a situation that may become violent or involve emotional abuse, regardless of the good intentions of the others. The method of disclosure is greatly simplified if the partner is not considered dangerous or is a nonromantic sexual partner (“a friend with benefits”).

**Intervention Strategies**

In regards to preventing HIV infection for women in abusive relationships or avoid reinfection, participants shared what they desired in a sexual risk and IPV prevention intervention. The conversation focused on four main subthemes. The first subtheme, *getting out*, focuses on safety planning for leaving abusive relationships, identifying warning signs of abusive relationships, knowing one’s own strengths and boundaries, and standing up for oneself,
(i.e. learning the difference between assertive and aggressive). Steps for safety planning included: information gathering, developing support systems, and gathering resources—such as important papers and money—to prepare for leaving an abusive relationship. The second subtheme, reaching for help, is primarily directed towards identifying community resources for both domestic violence and HIV/AIDS prevention, such as shelters and clinics. Women discussed that sometimes they had no one to turn to, or did not know where to turn, so providing this information so that they know where to reach for help when they decided it is best for them.

Personal healing was the third subtheme, which primarily targets their empowerment, from seeking counseling to developing self-esteem. Fourth, strength in numbers was a subtheme in which women talked about addressing intimate partner violence with other women who have shared similar experiences through support groups or women’s conventions, as well as addressing intimate partner violence as a community by starting a public dialogue and awareness campaigns. An important component of this was building and utilizing support systems, as illustrated in a vision shared by a participant:

A group like this where you know that everybody…who’s in the circle has experienced what you’ve experience you can speak freely. You help each other from each other’s situations. Some type of support system…It should be something that is…constant.

Finally, regarding program logistics, participants indicated the need for the intervention to be delivered by trained peers who “are real, hardcore, and have been through some of this shit that we’ve been through to actually get out there and reach everyone,” (AA Survivor of Abuse). They also emphasized having a nonjudgmental environment, saying that “it feels good to get up and talk, you know…not having anybody judge me.”
Discussion

The findings of this qualitative study offer a more in depth picture of the complex, bidirectional understanding of HIV/AIDS and IPV among African American women—from IPV as a risk factor for HIV and possible reinfection to IPV as an impact on a seropositive woman’s decision to disclose—with a specific emphasis on cultural influence and intervention strategies. Participants confirmed the findings in the literature around gender inequalities (Kyomugisha, 2006; Quinn, 2005; Türmen, 2003; Zeirler, 1997) and identified several means through which gender inequality impacts sexual risk.

Violence and fear in relation to male-female roles of male dominance and female compliance was a prominent result in the study. While literature has previously established the link between intimate partner violence and HIV infections (Gielen et al., 2007) the stories and experiences of these participants are informative in that they guide us towards future directions in developing culturally competent intervention strategies, both in regards to HIV prevention for women who have experienced IPV and for disclosure strategies for seropositive women who are afraid of disclosing their status to violent partners.

The difficult bind for practitioners working with clients with these compounding issues is helping a client safely navigate what is possible and what is safe. It is important to assess each situation on a case-by-case basis. What will happen if a woman tries to negotiate safe sex with an abusive partner? How can an HIV-positive woman disclose her status to a potentially abusive partner? Should she even try if it would put them at risk for future violence? It would be naïve to think that providing HIV educational materials and promoting safe sex and disclosure strategies would lead to automatic change on either the part of the women themselves or their abusive partners; however, it would be hopeless and counterproductive to give up all together,
saying “Don’t disclose your status,” or “Don’t try to negotiate safe sex.” The ideal balance must be met after careful contextual analysis. Thus, a careful assessment and strategic safety planning, specifically sexual safety planning whereby a woman considers protecting herself from HIV infection (or reinfection) as important as other abuse-related harm, utilizes the safest techniques possible to say no when she does not want to have sex, and has the power to fully control condom use and safe sex.

In addition to focusing on individual level change, there is the opportunity for change on a larger scale, calling for HIV/AIDS and domestic violence service organizations to work together in a collaborative fashion to meet the needs of women with the overlapping health concerns. Unfortunately, workers at both types of service organizations often feel overwhelmed with the multiple barriers faced by their clients and the difficulty of coordinating client care across different organizations for their intersecting issues, most notably health, mental health, domestic violence, HIV positive status, substance abuse, and poverty. Looking at these challenges in the context of living with or leaving abusive intimate partners portrays a complex environmental context that deserves further exploration. Wrap-around service models and cross-agency collaboration are essential to bridging these resources together. In this way, agencies can support their clients and empower them towards holistic healing and recovery as opposed to addressing problems as separate, mutually exclusive issues.

On a community level, continued advocacy by both the domestic violence and HIV/AIDS field is necessary to further reduce HIV/AIDS risk and prevent intimate partner violence. Practitioners developing education and awareness campaigns need to be mindful of the cultural context in which participants live when targeting their messages. While the field of HIV/AIDS has come a long way in the past three decades since the earliest AIDS diagnosis, there is still a
great deal of stigma surrounding the disease. Similarly, despite great strides in the domestic violence and sexual assault movement, there remains a social and cultural silence around intimate partner abuse and sexual violence. Supporting the advocacy for political and social change and educating the community with primary prevention techniques will be beneficial in continuing to shift the public consciousness in a direction that no longer accepts violence against women, combats institutional exclusion of African American women, prioritizes sexual health and sexual safety, and recognizes the relationship between these two public health concerns.

Limitations

Despite the value of the data gathered in this study, there are several limitations that must be considered. First, as this was qualitative research with a relatively small sample size, these findings cannot be generalized. Rather, the findings should be seen as a probe into the nuances of these overlapping health concerns for these participants. In addition, our study design was such that it only examined HIV and IPV from the perspective of female partners; it did not take into consideration the participants’ intimate partners’ perspectives. Another limitation is the potential for sampling bias; as focus groups were conducted in two different geographical locations, the nuances of these locations may impact the perspectives of the participants.

Conclusion

Recognizing the complex cultural construct of African-American women’s lives with intersecting HIV and IPV is essential to providing them the tools for protecting themselves. Efforts at developing culturally competent interventions and safety plans to change individual attitudes and behaviors must be coupled with community and societal-level interventions for sustainable change in addressing these issues.


