

“Shackled with HIV:” HIV-Positive Women’s Experiences of Gender-based Intimate  
Partner Violence

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SOWK 554C: Qualitative Methods in Social Work Research

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May 2, 2008

**Abstract**

Women as a subgroup are among the fastest growing population acquiring HIV in Canada, and HIV-positive women appear to experience gender-based intimate partner violence (IPV) more frequently and severely than their HIV-negative counterparts. Although HIV/AIDS and IPV have been linked, there is a lack of programs and policies that integrate these epidemics and are adapted to women's needs. This qualitative research study in Vancouver, Canada, details women's perceptions of the relationship between HIV and IPV and their experiences of seeking support from AIDS service organizations when dealing with IPV. In-depth interviews were conducted with 6 HIV-positive women who are survivors of IPV. Data emerged into two themes: HIV is a breeding ground for abuse and blame for HIV infection manifests in abuse. In addition to the themes, women talked about how agency support is meaningful when workers "stick" beside women, and how workers with experiential knowledge ensure empathy and understanding. Analysis highlights that HIV/AIDS initiatives should incorporate strategies for stopping IPV and supporting women who experience IPV through utilizing peer support. Also, collaboration needs to occur between HIV-positive women and social workers to devise education and training on the links between HIV/AIDS and IPV and "best practices" for social workers.

## Introduction

“Women have 99% of problems to begin with, and HIV-positive women have that extra 1%, so being HIV-positive is the straw that broke the camels back.”

### Participant

In the most recent summary of trends and developments related to the HIV epidemic in Canada, the Public Health Agency of Canada (2006) reports disturbing statistics in relation to women and HIV/AIDS, particularly concerning Aboriginal women. Women represent an increasing proportion of those with positive HIV test reports in Canada and in 2005 accounted for one quarter of such reports. The national HIV prevalence (total number living with HIV) estimates indicate that the number of women in Canada living with HIV, including those with AIDS, continues to grow. By the end of 2005, an estimated 11,800 (10,000-13,500) women were living with HIV, accounting for about 20% of the national total.

Ethnicity, race, class, and age are among the major distinctions shaping rates of HIV infection in women (Raimondo, 2008: 391). Some women are more vulnerable to HIV infection as a result of structural violence, what doctor and anthropologist Paul Farmer (2001) describes as those “historically given (and often economically driven) processes and forces that conspire to constrain individual agency” (79). HIV/AIDS has a significant impact on Aboriginal women; during 1998-2005, women represented 47.3% of all positive HIV test reports among Aboriginal peoples as compared with 20.5% of reports among non-Aboriginal peoples (Public Health Agency of Canada, 2006). The complex vulnerabilities of Aboriginal women stem from a legacy of oppression and colonization and the multigenerational effects of social isolation, discrimination,

entrenched poverty, and the residential school system (Bourassa, McKay-McNabb, & Hampton, 2004; Culhane, 2003; Farley, Lynne & Cotton, 2005; L'Hirondelle, 2006; McKay-McNabb, 2006; Neron & Roffey, 2000; Shannon, Kerr, Allinott, Chettiar, Shoveller & Tyndall, 2008). In short, the high rates of HIV transmission among Aboriginal women in Canada are rooted in the enduring effects of European expansion and in the racism and sexism with which it was associated (Farmer, 2004).

Gabor Maté, a Vancouver-based physician and writer, asserts, “It’s absolutely impossible to talk about women and HIV without placing the discussion in the context of pervasive misogyny” (Van Cleaf, 2003: 13). Service providers at Positive Women’s Network (PWN) (2007), a Vancouver-based AIDS service organization (ASO) that serves women living with HIV/AIDS across British Columbia (BC), have long argued that although HIV is labeled a “chronic manageable disease,” as a result of structural forms of gender inequality, this idea is not a reality for most women living with HIV/AIDS. Although women face biological vulnerability to HIV infection, many of the underlying factors of the high rates of HIV infection in women are socially constructed. For example, women’s invisibility in the AIDS research agenda, sexual stigma and stereotypes, women’s limited time and money due to the multiple family roles they fulfill, women’s relegation to the “pink collar ghetto,” an unsympathetic medical system, power imbalances in relationships, and fear of disclosure are all factors that influence women’s infection rates and women’s health status once infected with HIV (PWN, 2007).

“Women,” as a distinct class, have been visible in varying and often inconsistent ways in AIDS research, policy and services (Raimondo, 2007: 380). Given that the number of women living with HIV is steadily increasing, especially among Aboriginal

women, it is pertinent that HIV-positive women's lived experiences enter the realm of AIDS research, policy and services. Concerns about the association between HIV/AIDS and violence have been fueled by studies reporting that violence is highly prevalent in HIV-infected women (Gielen, McDonnell, Burke & O'Campo, 2000; Kirkham & Lobb, 1998; Koenig & Moore, 2000; Neron & Roffey, 2000). American-based research suggests HIV-positive women experience gender-based intimate partner violence (IPV) at rates comparable to HIV-negative women from the same underlying populations; however, their abuse seems to be more frequent and more severe (Gielen, Ghandour, Burke, Mahoney, McDonnell & O'Campo, 2007). So, part of exploring HIV-positive women's lived experiences includes investigating their experiences of IPV.

IPV is a global health and human rights issue within the larger epidemic of violence against women. A significant barrier to exploring the relationship between HIV and IPV is the lack of standard definitions of IPV. The literature calls for researchers in this field to come to consensus on issues of measurement and assure widespread adoption of agreed-on definitions and measurement tools (Gielen et al., 2007; Maman, Campbell, Sweat & Gielen, 2000). Barnett, Miller-Perrin and Perrin (2005) propose five IPV subscales; they suggest defining intimate partner violence as consisting of three kinds of behaviours: (a) physical violence, (b) sexual violence, and (c) threats of physical and/or sexual violence. They go on to conclude that abuse should be defined broadly to include the above three types of violent behaviours and two more forms: (d) stalking and (e) psychological/emotional abuse. This definition fits with the United Nations General Assembly's (1993) definition of violence against women in its *Declaration on the Elimination of Violence Against Women*. At an individual level, the aspect of "gender-

based violence” encompassed in IPV comes from the idea that intimate partner violence describes physical violence directed against a woman by a current or ex-husband or boyfriend (Jewkes, 2002). At a structural level, “gender-based violence” is derived from the idea that violence against women is a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men, and to the prevention of women’s full advancement (Federal-Provincial-Territorial Ministers Responsible for the Status of Women, 2002).

Beyond data addressing initial disclosure, very little is known about the association between HIV status and violence as it evolves over time and the meaning women assign to it in relation to their HIV status (Gielen et al., 2000; Koenig & Moore, 2000). In order to understand women’s experiences of seeking support for IPV we must understand the context within which they view IPV. Gielen et al. (2000) recognize this connection in their research on HIV disclosure and violence; they address the violence women living with HIV/AIDS experience and how the violence relates to their diagnosis and disclosure. Similarly, the current study looks at women living with HIV’s experiences of IPV at disclosure and overtime, and their perspectives on how IPV relates to their HIV status. Notably, while Gielen et al. (2000) focus only on women’s experience of IPV immediately after disclosure, this study explores women’s experiences of IPV from disclosure onwards.

Although HIV and IPV have been linked, programs and policies to address these two problems are rarely integrated (Gielen et al., 2007; Quiroga, 2004; Varcoe, Dick & Walther, 2004). The literature calls for research into how ASOs can tailor their programs

to address IPV and meet the needs of women (Koenig & Moore, 2000). ASOs provide education aimed at preventing the transmission of HIV, advocacy to reduce the stigma related to AIDS and support services to those affected by HIV (Cain, 1997). In order to tailor programs and policies so they address women's needs, an understanding of their experiences of IPV is required.

Exploring IPV and HIV is important because of the numerous health consequences the combination of these two epidemics present for women and their families. Significantly, the literature suggests HIV-positive women are more negatively affected by abuse in terms of quality of life and mental health issues, including suicide risk (Gielen et al., 2007; Moreno, 2007). Moreover, the pattern/sequence of violence against HIV-positive women can interfere with their health care, including their compliance with HIV treatment, and expose them to new traumas (i.e. revictimization) and difficulties coping (Moreno, 2007). Abused women in general have been found to have higher rates of unsafe sexual practices and a host of other reproductive health problems (Gielen et al., 2000).

There is a lack of Canadian-based research that examines the relationship between IPV and HIV/AIDS. Canadian research suggests women who face discrimination on various grounds are more vulnerable to violence and abuse and face greater barriers when seeking services (Federal-Provincial-Territorial Ministers Responsible for the Status of Women, 2002). Canadian research has also identified violence and abuse as main concerns for HIV-positive women (Kirkham & Lobb, 1998; McKay-McNabb, 2006). However, little is known about HIV-positive women's experiences of IPV and their perceptions of the relationship between IPV and HIV. Given that women living with

HIV appear to be at higher risk for more frequent and more severe violence than HIV-negative women and there is limited knowledge upon which to base strategies and interventions that address the lived realities of women living with HIV who experience IPV, this research aimed to explore HIV-positive women's experiences of IPV, their perceptions of the relationship between HIV and IPV, and their experiences of seeking support from ASOs when dealing with IPV in Vancouver, Canada. Through qualitative research that draws on feminist oral histories and standpoint theory, I examine HIV-positive women's narratives on their "lived experiences" related to IPV and consider how this information can inform AIDS research, policy and services. Beyond contributing to the field of qualitative social work research on the topic of women, IPV and HIV/AIDS, the study makes a modest but relevant contribution to knowledge, in general.

## **Method**

In this study, feminist qualitative methodology was used to gain an in-depth understanding of the experiences and views of women living with HIV who identified as survivors of IPV and had sought support at ASOs for IPV. Although there is no unified approach to feminist research, feminist researchers share the common need of centering and "problematizing" women's diversity of views and life experiences (Madriz, 2003). One-to-one in-depth interviews with six women were conducted. By exploring "views and lived experiences," I attempted to put "faces" to the numerical data on women, HIV and IPV (Gahagan & Loppie, 2001). My intention in using this methodology was to place women at the center of the inquiry, not as the subjects of the research, but to

capture the material of these women's lives from the standpoint of the women themselves (Kasper, 1994).

One of the principles of feminist research has been expressed in the phrase “research by, about, and for women;” this has resulted in a large amount of literature on women based on oral histories, in-depth interviews, and testimonies aimed at narrating the everyday realities of women's lives (Acker, Barry & Esseveld, 1983; Gluck & Patai, 1991; Harding, 1987; Kasper, 1994; Madriz, 2003). The methodology draws from the aforementioned literature, and, in particular, builds on the work of Sandra Harding (1987, 2004) and Catherine Kohler Riessman (2008). Harding (2004) highlights how oppressive structures intersect in different ways for different groups, and women's varying accounts of their lived experiences allows each oppressed group to have its own critical insights about the larger social order to contribute to the collection of human knowledge (9). Riessman emphasizes that narratives are connected to the flow of power in the wider world; connecting private constructions of identity and “deep structures” about the nature of life becomes possible through the close analysis of stories (8-10). In the interviews, I explored women's critical insights about the nature of HIV and IPV and, in my analysis of the interviews, I attempted a “close reading” in order to connect these insights with “structures” related to the larger social order.

### **Self-Reflexivity**

One implication of feminist qualitative methodology is that the knower and the known cannot be unambiguously separated, as is assumed by the norm of objectivity; accordingly, the role of the researcher must be seen as central to the research (Henwood & Pidgeon, 1995: 9). As the researcher, my commitments should be fully described and

discussed and my values acknowledged, revealed and labeled (Reinharz, 1983: 172). I am a white, privileged woman who is non-HIV-positive. I have worked at PWN for the past two years and at a sexual assault centre for the past four years. From my experience at these organizations, I have observed a dislocation between the women's movement, specifically the anti-violence movement, and the AIDS movement. I understand from first-hand experience Quiroga's (2004) account of the difficulties of uniting the women's movement and the AIDS movement. I believe HIV/AIDS needs to be on the feminist agenda; the feminist agenda has not given enough importance or place to HIV/AIDS issues. My decision to use feminist qualitative methodology is based on my commitment to placing HIV/AIDS issues on the feminist agenda. In addition, my decision to use feminist qualitative methodology is informed by my adherence to "radical" social work values; that is, empowerment in terms of communities taking control of their circumstances, achieving their own goals, and maximizing the quality of their lives by having a greater voice in institutions, services and situations which affect them (Shardlow, 1998: 31).

### **Participant Recruitment and Eligibility**

Participants in this study were selected from PWN. After obtaining ethics approval from the board at PWN, flyers were posted and participants were recruited by agency staff. To qualify, participants were identified by the agency staff as a person over age 19 (i.e. able to give informed consent), who is HIV-positive, self-identifies as a woman, is a survivor of IPV that occurred post HIV-disclosure, sought support at an ASO for IPV, and is conversational in English (because I did not have the funds for an interpreter). 9 women contacted me about participating in the study, of who 6 met the

criteria to participate in the study. Due to time constraints, I chose to discontinue recruiting participants after interviewing 6 women. This research also received ethical approval under the University of British Columbia Ethics Review Board.

### **In-depth Interviews**

The in-depth interview provided a setting in which detailed stories about sensitive topics such as HIV and IPV emerged easily and the women did not need to worry about a large audience (Moreno, 2007). Women were asked a series of broad, open-ended questions related to their experiences of and views on abuse, HIV and seeking support. The women were asked to talk about their experiences of IPV, specifically after they disclosed their HIV status to their boyfriend/husband and overtime since then. They were also asked to talk about their experiences of seeking support at ASOs for IPV. Using qualitative techniques such as probing, I encouraged participants to describe how, if at all, their HIV infection mediated their abuse.

The face-to-face interviews lasted between 25 to 45 minutes. Interviews took place in a private office at PWN. I purposefully chose this location because for many women, it is a familiar and safe space; using participants' familiar spaces further diffuses the power of the researcher, decreasing possibilities of "Otherization" (Madriz, 2003: 374). At the end of the interview, each women was compensated \$30 and given a "thank you" card. Confidentiality was explained and women signed a consent form prior to the interview.

### **Demographics**

Participants ages ranged from 42-49, with one participant aged 21. Four of the six participants self-identified as being of Aboriginal ancestry. The remaining two

participants self-identified as “white,” one of whom is transgender. Participants identified as living with HIV for between 4.5 to 21 years. Four of the six participants had children, one participant is a grandmother. Participants identified as being in relationships with their abusive partners for periods of time ranging from 16 months to 17 years. Three of the six participants had long term abusive partners who were HIV-positive, one participant’s abusive partner was non-HIV-positive, one participant identified as having multiple abusive partners who were non-HIV-positive, and one participant identified as having multiple abusive partners some who were non-HIV-positive and some who were HIV-positive. All of the participants were single or in non-abusive relationships at the time of the interview. Each participant had a history of addiction, and two participants identified as having worked in the sex trade. All of the participants live in Vancouver and are on disability assistance through the BC government.

### **Data Analysis**

With the permission of the participants, all interviews were audiotaped, transcribed verbatim and checked for accuracy. Copies of the transcripts were left at PWN for participants to pick up. I had hoped to debrief with participants about their transcripts and the findings, a tool that qualitative researchers use to ensure validity and credibility, but because of the transitory nature of the participants’ lives, after the interviews I was unable to make contact with the participants (Borland, 1991; Moreno, 2007: 343). I am aware of two participants who picked up their transcripts but they did not contact me directly post-interview.

In order to develop an interpretive and reflexive understanding of participants' narratives, I began with "holistic" data organization, which involved rereading each interview transcript with the objective of writing individual short interview summaries (Mason, 2002). In an effort to build explanations based on two alternative ways of "slicing" the data set, interview data were analyzed to identify thematic content and patterns as they emerged. Interview data were initially coded based on key concepts, and substantive codes were then applied for themes based on the initial codes. The "interview summaries" helped me to maintain the context for the quotes that were lifted out of the interviews during coding. All excerpts were given equal value, as the goal of qualitative research is broad description (Moreno, 2007: 343). Examples of codes include: being HIV-positive, violence, blame, self-esteem, support, lack of support, strengths, ASOs, and recommendations. I then grouped related codes into two themes: HIV is a breeding ground for abuse, and blame for HIV infection manifests in abuse. In addition to the themes, women talked about how agency support is meaningful when workers "stick" beside women, and how workers with experiential knowledge ensure empathy and understanding.

## **Results**

### *Theme 1: HIV is a breeding ground for abuse*

Women spoke about their perceptions of the relationship between HIV and IPV based on their own experiences. Many of the women linked their HIV status and the resulting low self esteem as "setting the stage" for IPV and causing them to "settle for less" in intimate relationships. Women thought that their HIV status exiled them to abusive relationships (Moreno, 2007: 344). For these women,

being HIV-positive allowed their partners' to take advantage of them. Women described how they felt "grateful" and "lucky" that anyone, even an abusive partner, demonstrated love and kindness towards them. Participants also mentioned that the realization of their own mortality, and the emotions that result from dealing with a chronic illness, made them particularly vulnerable to IPV. The difficulty of overcoming the cycle of abuse, especially if one is constantly sick, was discussed. One participant explained her experience of abuse after her HIV diagnosis:

[Being HIV positive] is just an absolute breeding ground for abuse because [he came] along and he figured he had me over a barrel because I was in such despair [about my HIV diagnosis].

Women expressed the complexities involved in living with HIV and the effects this has on self-esteem. Many identified as feeling shameful because of the stigma attached to HIV and feeling worthless because they were unable to work and on disability assistance. Speaking specifically about the stigma associated with HIV, one participant spoke to the reasons for HIV being a breeding ground for abuse:

The stuff [violence and abuse] this man was able to get away with because, yeah, she's just a slut and a prostitute and she's got HIV, ew.

Women's accounts of their lives negotiate the discrepancy between the self-image they have developed in the course of their everyday activities and the images of themselves that they receive from society (Candida-Smith, 2003). Another participant described how

IPV is related to the stress involved in being HIV-positive, particularly when both people in the relationship are HIV-positive:

Money problems, because it's so expensive when you're HIV, to eat properly, it's just really stressful... I think there is too much stress on both sides, if [your partner] hasn't dealt with his [HIV diagnosis]. I think with HIV there's always part of them that's going to be in denial. So, you don't deal with your whole situation. [Violence comes out of] frustration and denial.

Many of the participants had histories of trauma from childhood to adulthood.

Some participants rationalized the abuse as “normal” (Moreno, 2007). Women provided accounts of suffering severe physical and verbal abuse as children and as adults, and some women identified as having been in abusive intimate relationships prior to their HIV diagnosis. However, women highlighted that the severity of the abuse increased immediately after HIV disclosure and overtime since then. One participant illustrated this shift:

If I wasn't positive, I think he would have been [abusive] anyways. I don't think, I *know* he would have been. It's just being positive made the abuse worse. Well, fists and not just name calling [after I disclosed my HIV]. I could handle name calling. And then [after disclosing my HIV status] it would become fists.

Another participant described how disclosing her HIV status impacted her relationship:

He always talked down to me, like I was a big disease. If he doesn't have [HIV] and you do, it's like you're a big disease. And I didn't tell him [about my HIV

status] for the first year. And then we were together only four months after I told him because it just went downhill from there.

Women's accounts of the various types of IPV they endured showed that being HIV-positive shaped the severity of the abuse and also the types of abuse. Women emphasized their partner's public disclosure of their HIV status as a form of abuse; one participant referred to public disclosure of HIV status as "covert abuse." If their abusive partners were non-HIV positive, women discussed how their partners did not fully understand the enormity of public disclosure, whereas women had "everything" to lose from others knowing of their HIV status. One participant described her experience and shared her views:

If I'm sitting in the bar, same bar I've been drinking 20 years, someone will come up [who has heard from her partner that she is HIV-positive]: "Hey, she's got AIDS, you know. She's got full blown AIDS"... [Attached to that statement is a certain] kind of stigma. And that is slander as far as I'm concerned... It's hard enough to put up with this disease and try to possibly as much as you can keep it to yourself.

For some women, public disclosure was a precursor to physical abuse:

[My partner says:] "I am going to tell them that you're sick." And I'll say: "I already told them I'm sick. And you have no right to say I'm sick and what my illness is. You have no right to even know my business or my affairs." We'd start arguing. And then he'd be banging at the door and then violence would start.

One participant conveyed the magnitude of being "publicly outed:"

If he beat me up then only he knows I am [HIV] positive, right? But since he yelled [my HIV status] out in front of [everyone on] Hastings Street, everybody knows. I'd rather nobody know and get hurt then everybody know and not get hurt. But I got both so it doesn't matter... When I go down there, I don't know if they remember it but I feel like they're looking at me, like: "Oh, hey, she's got HIV, look!" So I just don't go down there.

*Theme 2: Blame for HIV infection manifests in abuse*

The theme of blame arose in many of the participant's narratives in terms of their abusive partners holding them responsible for their HIV infection or, if their abusive partner was non-HIV positive, reprimanding them for the possibility HIV transmission. Many of the women expressed with certainty that they did not infect their abusive partners, but regardless of this fact they were held accountable for their partner's HIV infection. Blame for HIV infection was depicted as being constantly present in their relationships as an "underlying" source of anger. As a result of the blame and abuse they endured in their relationships, women articulated feeling "shackled" with their HIV status. One woman described how her partner utilized blame for HIV infection as a motive for physical abuse:

He thinks I got him sick.... [While beating me he yelled:] "Look what you did!"

He thinks I got him sick.

One participant discussed how her involvement in the sex trade was used as rationale for her HIV infection and for blame:

Oh, well, he used to blame me a lot saying I gave it [HIV] to him and I was hosing around, slutting around, probably selling my butt, all kinds of things.

Many of the women expressed how their abusive partners would use blame for HIV infection as a control mechanism. Women articulated how when other problems arose, such as the need for drugs or lack of money for living expenses, blame for HIV infection would commence. One participant described how blame for HIV infection resulted in her being wholly responsible for her and her partner's survival:

[Since he was diagnosed with HIV] Everything was my fault, put it that way.

Like, [he would say:] "You gotta take care of this now, you gotta bring this home, you gotta bring drugs home. It's all yours. You gave it [HIV] to me, you know"... Since he found out he had HIV, it's his routine. I get beat up. Ended up in the hospital a couple of times.

Another participant gave a chilling account of her partner's threats in relation to his HIV transmission:

I think that's what he wanted, to kill me because I gave it [HIV] to him. He was saying that I'm going to go first.

The intense guilt women were made to feel for being HIV-positive added an element of psychological/emotional abuse to the physical and sexual violence they experienced.

## **Discussion**

The study provides exploratory and in-depth accounts of women living with HIV about the contextual experiences of IPV and HIV status (Moreno, 2007). The main themes illustrate the deep and complex connections between gender, abuse, trauma, blame and HIV. In addition, the themes highlight the importance of HIV/AIDS initiatives incorporating strategies for stopping IPV and supporting women who experience IPV (Gielen et al., 2000; Gielen et al., 2007; Maman et al., 2000; Martin &

Curtis, 2004). These strategies should include improving the status of women, reducing the stigma of HIV/AIDS, and reducing the norms of violence (Jewkes, 2002; Van Clieaf, 2003).

In their review of American-based literature concerning HIV and violence against women, Koenig and Moore (2000) write: “These findings suggest that much of the violence experienced by HIV-infected women is probably attributable to the social and behavioural contexts (i.e. using illicit drugs, trading sex for money, having sex with multiple partners, and having sex with men who use drugs) that characterize the lives of many women with HIV” (104). The intersection of violence against women and HIV is more complex than Koenig and Moore (2000) concede; they overlook that violence experienced by HIV-infected women may also be attributable to the very fact that they are HIV-positive. The current findings suggest simply being HIV-positive can be an influencing risk factor for violence committed against women (Gielen, O’Campo, Faden & Eke, 1997; Moreno, 2007). As documented by the women in the study, the stigma associated with HIV, coupled with poverty and addiction, creates a toxic recipe for women in intimate relationships.

Consistent with previous literature, women in the sample reported experiencing frequent and severe IPV (Gielen et al., 2000; Gielen et al., 2007; Maman et al., 2000). The data provided examples of how women’s HIV status was associated with IPV; for example, women mentioned that their abusive partners would verbally recall their HIV status directly prior to or during incidents of physical or sexual violence. Few HIV/AIDS counselors and service providers receive the training necessary to assess and refer women who experience IPV, causing a valuable opportunity for violence prevention to be missed

(Koenig & Moore, 2000; Maman et al., 2000). Many participants reported that ASOs were not equipped to deal with IPV. The study demonstrates that IPV is a topic that needs to be on HIV/AIDS counselors and service providers' radars.

There is a need for interventions that target HIV-positive women who may be experiencing IPV (Gielen et al., 2007). Women spoke about the importance of workers "sticking" beside them before, during and after their abusive relationships, rather than offering judgmental advice or referring them on to another service provider.

So, collaboration needs to occur between HIV-positive women and social workers to devise education and training on the links between HIV/AIDS and IPV and "best practices" for social workers (Teti, Rubinstein, Lloyd, Aaron, Merron-Brainerd, Spencer, Ricksecker & Gold, 2007). The striking overrepresentation of women of Aboriginal ancestry among those living with HIV, and the historical and ongoing oppression of this population, highlights the need for Aboriginal-led interventions that mitigate trauma and support indigenous health and social service strategies (Shannon et al., 2008).

Strategies for stopping IPV and supporting women who experience IPV should utilize peer support (Teti et al., 2007). Many of the participants discussed the ease with which they could articulate their IPV-related issues when they were speaking to someone with experiential knowledge. Women appealed for more services by and for HIV-positive women; they described the empathy and understanding they received from their peers as profoundly meaningful and instrumental in leaving their abusive partners and in their healing journeys.

The study has several limitations, including the small sample size which was drawn from an ASO serving women living with HIV/AIDS. I recruited women who self-

identified as having experienced IPV after HIV disclosure, and therefore, the experiences of women who may have been survivors of IPV but do not identify as such are not represented here. It was limited to a specific geographic area, so the findings cannot be generalized to all Canadian women living with HIV. It should be emphasized that I am not attempting to define a casual pathway between being HIV-positive and experiencing IPV; rather, I am describing the dimensions of six HIV-positive women's lives in relation to IPV. The data serves as a basis for further research using larger samples and different methods.

More Canadian-based research on women, HIV/AIDS and gender-based intimate partner violence is urgently needed. "Women" is a diverse category and further research about HIV and IPV needs to focus on specific groups of women, in particular Aboriginal women, immigrant and refugee women, and young women, in order to better understand the complexity of these epidemics and how they distinctively affect certain groups. When women seek support related to IPV, the violence committed against them by their partners can often increase; increased IPV can be motivated by men's knowledge of supportive or protective resources for women, particularly in men who believe such services deprive them of their rightful authority or control in intimate relationships (Dugan, Nagin & Rosenfeld, 2003). More research into the potential of an association between these elements is required prior to designing services and programs for women living with HIV who experience IPV. Although the findings from the study support HIV/AIDS initiatives incorporating strategies for stopping IPV and supporting women who experience IPV, much work remains to be done to inform social work practice,

expand understanding of the links between HIV/AIDS and IPV, and render visible HIV-positive women's voices on the HIV/AIDS and anti-violence research agendas.

**Acknowledgement**

This study was funded by the "Community Care Fund" through the School of Social Work at the University of British Columbia.

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