A Lifetime of Violence: Results From an Exploratory Survey of Mexican Women With HIV

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Despite recognition that traditional Mexican gender norms can contribute to the twin epidemics of violence against women and HIV, there is an absence of published literature on experiences of violence among Mexican women with HIV. We conducted a cross-sectional survey with 77 HIV-infected women from 21 of Mexico's 32 states to describe experiences of violence before and after HIV-diagnosis. We measured lifetime physical, sexual, and psychological violence; physical violence from a male partner in the previous 12 months; and physical and psychological violence related to disclosing an HIV diagnosis. Respondents reported ever experiencing physical violence (37.3%) and sexual violence (29.2%). Disclosure of HIV status resulted in physical violence for 7.2% and psychological violence for 26.5% of the respondents. This study underlines the need to identify and address past and current gender-based violence during pre- and post-HIV test counseling and as a systematic and integral part of HIV care.

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Gender inequality, in its multilevel and culturally diverse manifestations, contributes to violence against women and is a driver of the HIV pandemic among women and girls (Heise, 1998; Joint United Nations Programme on HIV/AIDS [UNAIDS], 2010b; Krishnan et al., 2008). These twin epidemics interact synergistically and are important public health issues for women internationally (Campbell et al., 2008; UNAIDS, 2010b). Traditional Mexican gender norms prescribe male dominance and female submission, and include related cultural constructions of sexuality that encourage male risk-taking (including having multiple sexual partners) while dictating female monogamy and sexual passivity (Herrera & Campero, 2002; Kendall, 2009a). These dominant Mexican gender norms are hypothesized to contribute to both violence against women and women's vulnerability to HIV infection (Herrera & Campero, 2002; Wiedel, Provencio-Vazquez, Watson, & Gonzalez-Guarda,

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2008). Yet our literature review did not identify any studies that looked specifically at the relationship between violence against women and HIV in Mexico or that documented experiences of violence among Mexican women living with HIV.

Several international studies have linked sexual and physical violence from a male partner to higher rates of HIV infection among women (Dunkle et al., 2004; Silverman, Decker, Saggurti, Balaiah, & Raj, 2008). In the Latin American context, a Brazilian study found that women with HIV were more likely to report severe and recurrent experiences of violence than women without HIV but couldn't identify whether experiences of violence were related to living with HIV or occurred prior to diagnosis (Barros, Schraiber, & Franca-Junior, 2011). A Chilean study found that low-income women who experienced intimate partner violence (IPV) were more likely to report risk behaviors for HIV acquisition than those who didn't experience IPV, primarily unprotected sexual intercourse and intercourse with a partner of unknown HIV-status (Miner, Ferrer, Cianelli, Bernales, & Cabieses, 2011). These Latin American results echo international findings that violence increases women's risk for HIV infection through both indirect and direct relationships. Indirect relationships between violence and increased risk for acquiring HIV include the associations between experiencing violence as a child or an adult and subsequent substance abuse and multiple sexual partners (Campbell et al., 2008). Additionally, men who perpetrate IPV exhibit increased HIV-acquisition risk behaviors (Campbell et al., 2008; Gonzalez-Guarda, Peragallo, Urrutia, Vasquez, & Mitrani, 2008; Raj et al., 2006; Silverman, Decker, Kapur, Gupta, & Raj, 2007). Direct pathways include the greater biological risk of HIV infection during violent or forced sex, decreased ability to negotiate condom use among women (suggesting condom use is a feared or actual trigger for violence), and the decreased likelihood of condom use among men who perpetrate IPV (Campbell et al., 2008; Manfrin-Ledet, & Porche, 2003). Finally, women with HIV report higher rates of physical, sexual, and psychological violence than the general population, and may suffer violence as a result of disclosing their HIV status (Campbell et al., 2008; Gielen, McDonnell, Burke, & O'Campo, 2000; Semrau et al., 2005).

HIV and Violence Against Women in Mexico

In 2009, there were an estimated 220,000 Mexicans living with HIV, of which 59,000 were women (UNAIDS, 2010a). While men who have sex with men are the population most affected by HIV in Mexico, the evolution of the epidemic is characterized by an increasing proportion of infections attributed to heterosexual transmission and steady growth in AIDS cases among women, particularly young women from rural areas and indigenous women (De Luca et al., 2010). Mexican women acquire HIV almost exclusively through heterosexual contact (Centro Nacional Para la Prevención y el Control del VIH/SIDA [CENSIDA], 2009b). Existing research suggests most women were exposed to HIV as a consequence of the sexual behaviors and/or drug use of their stable male partners, especially men who have sex with men as well as women (Kendall, 2009a).

Violence against women is common in Mexico. A large nationally representative sample of women using public health care services (N = 26,042) documented at least one act of physical, sexual, or psychological violence as a child or an adult among 60.4% of respondents, 34.5% reported some form of IPV in their lifetimes, 17.3% reported sexual violence in their lifetimes, and 9.8% reported physical IPV in the previous 12 months (Olaiz, Rojas, Valdez, Franco, & Palma, 2006). Another nationally representative household survey (N = 21,631,993) found that 19.2% of women reported physical and 9.0% reported sexual violence from the current or most recent male partner, and 10.2% reported physical and 6.0% reported sexual IPV within the previous 12 months (Instituto Nacional de Estadistica y Geografia [INEGI], 2006).

Research Gaps

Despite the prevalence of violence against women in Mexico and the increasing numbers of Mexican women living with HIV, our literature review did not identify studies on violence experienced by Mexican women living with HIV or, indeed, any studies from Latin America that specifically addressed violence against women as a consequence of an HIV diagnosis. The present paper addresses this research gap.

Methods

Participant Recruitment and Data Collection

In April and May of 2008, the Mexican chapter of the International Community of Women Living With HIV/AIDS conducted capacity-building workshops for women with HIV from the north, center, and south of Mexico. Women with HIV were identified through their participation in HIV civil-society networks and support groups. Women with HIV were invited to participate in capacity-building workshops based on peer organizers' evaluations of their potential to be group facilitators and leaders. The goal of the workshop was to expand the national network of women with HIV; to increase participants' knowledge of gender, HIV-related stigma and discrimination, and sexual and reproductive health among women with HIV; and to build the capacity of women with HIV to facilitate and replicate the workshop with their peers. Eighty women attended the workshops at which the research was conducted and 77 women from 21 of Mexico's 32 states completed the survey. Inclusion criteria for the study were being a woman living with HIV, attending the workshop, and agreeing to complete the survey. There were no exclusion criteria for survey completion for the women with HIV who participated in the workshops.

In collaboration with the International Community of Women Living With HIV/AIDS in Mexico, the Population Council's Mexico Office designed a written, self-administered survey in Spanish that was completed at the end of the workshop to (a) evaluate the workshops, and (b) assess the sociodemographic characteristics, sexual and reproductive health history and needs, and experiences of physical, sexual, and psychological violence among women living with HIV. Lifetime physical violence was defined in the questionnaire as being hit sufficiently hard to provoke visible bruising, broken bones, or other lesions. Physical violence from a male partner was defined as being hit, slapped, or otherwise intentionally hurt by a male partner. Sexual violence was defined as being forced to have sexual contact by either physical or emotional force. We asked a second question about being physically forced to have sexual intercourse; in the southern region, local workshop organizers excluded this question as it was found to be too invasive. In our survey, we defined psychological violence as experiencing verbal abuse, isolation, or threats. With the exception of physical violence from a male partner during the previous 12 months, we did not ask who perpetrated violence against women throughout their lifetimes or as a consequence of disclosing an HIV diagnosis. The research team wrote the survey questions after consulting previously validated instruments used to measure violence against women in Mexico (Olaiz, Rico, & Del Rio, 2003; INEGI, 2006). The survey instrument was reviewed and approved by the International Community of Women Living With HIV/AIDS in Mexico before application.

When the survey was distributed, members of the research team explained the voluntary and confidential nature of the survey, and facilitators were present to answer any questions participants had about the survey content. The conditions of informed consent were reiterated on the first page of the questionnaire. This survey was part of a larger study to explore sexual and reproductive health needs of women living with HIV in Mexico, of which the protocol was reviewed and accepted by the Population Council Institutional Review Board.

Data Analysis

We analyzed the data using the Statistical Package for the Social Sciences, version 14.0. We used descriptive statistics to analyze sociodemographic characteristics and experiences of violence. The denominator for the proportions we are reporting is the pool of individuals who answered each question. We conducted bivariate analysis to identify associations between experiences of violence and women's marital status (*married/common law* vs. *single, widowed, or separated*), living situation (*with family members* vs. *nonfamily members or alone*), reported occupation (*housewife* vs. *other*), and economic contribution to the monthly household income (*yes* vs. *no*). We also analyzed the relationship between experiencing HIV-related discrimination from health care providers and experiences of violence. We used Pearson's chi-square at .05 level of significance

[CI = 95%] and Fisher's exact test to compare categories with fewer than five cases.

Results

Sociodemographic Profile of Participants

Of 80 Mexican women with HIV from all regions of the country who participated in the training workshops facilitated by the International Community of Women Living With HIV/AIDS in Mexico, 77 completed the survey (response rate 96.3%). Of the respondents, 29.9% were from southern Mexico, 28.6% from northern Mexico, and 41.6% from central Mexico. As shown in Table 1, 44.2% of the women were currently in a stable relationship (married or common-law), mean age was 38.8 years (*SD* = 9.1), and most women had completed some secondary or postsecondary education (67.1%). The sample was divided almost evenly between self-defined housewives (52.0%) and women with other occupations (48.0%), but regardless of reported occupation, most women made a monetary contribution to the household income (68.4%). Household monthly family income ranged from $75–$1900 USD, with a mean monthly income of $300 USD. Almost all of the women (98.5%) reported monthly household incomes below the Mexican national average of 930 USD (INEGI, 2009). About half of the women faced food insufficiency at the household level. In 2008, the cost of the most basic monthly food basket was estimated at 90 USD per capita a month in urban areas (CONEVAL, 2011). If we assume a household of two adults and two children, with children consuming half as many calories as adults, the minimum household income required to meet basic food needs in 2008 was 270 USD per month. Just half of the women in our sample reported an income of 270 USD a month or greater. In addition, although the Mexican government provides free antiretroviral medication for people living with HIV, pharmaceuticals to treat opportunistic infections, laboratory tests, and transportation to medical visits can be significant expenses (Campero, Herrera, Kendall, & Caballero, 2007). Given the combination of a relatively low income with additional expenses related to managing a chronic illness, most women in our sample experienced economic difficulties.

Table 1. Sociodemographic Characteristics and HIV Treatment in a Sample of Mexican Women (*N* = 77) With HIV Infection

	N = 77	%
Age (years)		
19–29	13	16.9
30–39	28	36.4
40–59	36	46.7
Education[a]		
None	5	6.6
Primary school (partial or complete)	20	26.3
High school (partial or complete)	28	36.8
Postsecondary (partial or complete)	23	30.3
Current marital status		
Married/common-law	34	44.2
Single/divorced/separated/widowed	43	55.8
First marriage/common law relationship at < 20 years of age	50	64.9
Number of children		
0	6	7.8
1–3	54	70.1
> 3	17	22.1
Occupation		
Housewife	39	52
Other	36	48
Contributes to family income[a]		
Yes	52	68.4
No	24	31.6
Monthly household income[a,b]		
< 270 USD	34	49.3
> 270 USD	35	50.7
Cohabitation[a]		
Lives with family members	70	93.3
Lives alone or with nonfamily members	5	6.7
Taking antiretroviral treatment[a]		
Yes	66	86.8
No	10	23.2

a. Variable had missing data for some participants.
b. exchange rate calculated at 10.5 pesos per dollar using the average for April–May 2008 from Mexico's National Bank http://www.banxico.org.mx/portal-mercado-cambiario/index.html

Experiences of Violence Among Women With HIV

More than one third of the women with HIV (*N* = 28, 37.3%) in our study reported suffering physical violence in their lifetimes. More than one quarter of the women (*N* = 21, 29.2%) reported having been forced (physically or emotionally) to have sexual relations in their lifetimes. When asked whether they had been forced to have sexual intercourse through use of physical violence, 16 of the 52

participants (30.8%) who answered the question responded affirmatively. In questions about lifetime experience of physical and sexual violence, we did not ask women to identify the perpetrator. However, seven of 63 respondents (10%) reported physical violence from a male partner during the previous 12 months. With respect to violence as a result of sharing an HIV diagnosis, five of 69 (7.2%) women said that disclosure resulted in physical violence while 18 of 68 (26.5%) said disclosing their HIV status resulted in psychological violence against them.

Although our sample size was small, we explored associations between experiences of violence and women's current living situations with respect to cohabitation, occupation, and monetary contribution to the family income (see Table 2). We found statistically significant associations between living alone or with nonfamily members rather than with family members and having been physically forced to have sexual intercourse in their lifetimes ($p = .001$). Living alone or with nonfamily members was also associated with experiencing psychological violence as a consequence of disclosing an HIV diagnosis ($p = .004$). Women who made a monetary contribution to their family incomes were more likely to report having been physically forced into sexual intercourse than women who did not make an economic contribution to family income ($p = .034$). Women who self-defined as housewives were less likely to report psychological violence as a result of disclosing an HIV diagnosis than women who worked outside of the home ($p = .009$). We found no statistically significant differences in lifetime physical violence, lifetime sexual violence, physical violence from a male partner in the previous 12 months, or physical or psychological violence as a result of sharing an HIV diagnosis between women who were currently cohabitating with a male partner when compared to those who were not living with a male partner (data not shown in table).

HIV-Related Discrimination From Health Care Providers and Experiences of Violence

Most of the women (60.8%) in our sample stated that they had suffered HIV-related discrimination from a health care provider. We found a significant association between experiencing this form of discrimination and reporting psychological violence as a consequence of sharing the HIV diagnosis ($p = .013$). We did not ask women who perpetrated the psychological violence they experienced as a result of disclosing an HIV status and, therefore, can't assert whether or not the perpetrators of psychological violence as a result of disclosure were health care providers, intimate partners, family members, or others.

Discussion

Responding to Violence Against Women in HIV Care and Prevention

This exploratory study described experiences of violence in an understudied population, Mexican women with HIV. The most important and novel finding was the proportion of women with HIV reporting physical (7.2%) and psychological violence (26.5%) as a consequence of sharing an HIV diagnosis. The frequency of women in this sample reporting physical and psychological violence as a consequence of disclosure of an HIV diagnosis suggests that it is appropriate to identify past and current experiences of violence as part of HIV pre- and posttest counseling. It seems particularly important to screen HIV-infected women for violence during posttest counseling and also, independent of current or past experiences of violence, to help women assess the potential for physical and psychological violence when disclosing an HIV diagnosis to male partners, family members, friends, and health care providers. HIV posttest counseling that addresses violence can help women make informed decisions about whether, how, and when to disclose the diagnosis (Gielen et al., 2000; Maman & Medley, 2003). Our findings also suggest the need to identify and address violence against women as a routine part of HIV care. Screening for violence during posttest counseling should be seen as the first step in ongoing monitoring of violence that women may experience in their relationships (Gielen et al., 2000).

In Mexico, in addition to federal legislation to combat violence against women, there are specific legally mandated clinical protocols obliging health care providers to screen for domestic and sexual violence and make referrals to legal and social

Table 2. Experiences of Violence and Women's Living Situations

	Women's Living Situation								
	Co-Habitation (Alone or With Non-Family Members vs. With Family)			Occupation (Housewife vs. Other)			Contributes to Family Income (Yes vs. No)		
Experienced Violence (Yes)	Alone/ Nonfamily	Family	*p* Values	Housewife	Other	*p* Values	Yes	No	*p* Values
Physical violence (lifetime)	$N = 2$ (40.0%)	$N = 24$ (35.3%)	$p = .832$	$N = 12$ (32.4%)	$N = 14$ (38.9%)	$p = .565$	$N = 18$ (36.0%)	$N = 9$ (37.5%)	$p = .900$
Physical violence from male partner (previous 12 months)	$N = 1$ (25.0%)	$N = 6$ (9.4%)	$p = .318$	$N = 3$ (9.1%)	$N = 3$ (8.6%)	$p = .940$	$N = 5$ (10.6%)	$N = 2$ (9.1%)	$p = .843$
Sexual violence (lifetime)	$N = 2$ (50.0%)	$N = 18$ (27.3%)	$p = .329$	$N = 9$ (25.7%)	$N = 10$ (28.6%)	$p = .788$	$N = 15$ (31.3%)	$N = 5$ (21.7%)	$p = .404$
Physically forced sexual intercourse (lifetime)	$N = 4$ (100%)	$N = 11$ (23.9%)	$p = .001$[a] Fisher's $= .006$[b]	$N = 6$ (24.0%)	$N = 8$ (32.0%)	$p = .529$	$N = 13$ (39.4%)	$N = 2$ (11.1%)	$p = .034$[a] Fisher's $= .053$[b]
Physical violence as consequence of sharing HIV diagnosis	$N = 0$	$N = 5$ (7.7%)	$p = .683$	$N = 1$ (3.0%)	$N = 4$ (11.8%)	$p = .174$	$N = 5$ (11.1%)	$N = 0$	$p = .097$
Psychological violence as consequence of sharing HIV diagnosis	$N = 3$ (100%)	$N = 15$ (23.8%)	$p = .004$[a] Fisher's $= .018$[b]	$N = 14$ (41.2%)	$N = 4$ (12.5%)	$p = .009$[a] Fisher's $= .013$[b]	$N = 15$ (32.6%)	$N = 3$ (14.3%)	$p = .117$

a. The *p* value reported is the result of Pearson's chi square analysis. Statistically significant at .05 (CI 95%).

b. We conducted Fisher's exact test for all observations with fewer than 5 cases, but here we only report results from Fisher's exact test for comparisons that were statistically significant using Pearson's Chi Square at .05 [CI 95%].

support services (Secretaria de Salud, 1999, 2009). Effective implementation of this legislation and accompanying health care protocols have been slow in great part because many health care providers and decision makers share cultural norms that rationalize violence against women or consign gender-based violence to the private sphere as a "personal" matter (Herrera, Rajsbaum, Agoff, & Franco, 2006). Our study echoes the need for increased training for health care providers to help them identify and respond to violence against women. Strengthened monitoring and evaluation by relevant authorities, such as the National Center for Gender Equity and Reproductive Health, could provide impetus for the implementation of existing legislation and clinical protocols. This study also indicates that it would be important to include HIV-testing sites and HIV care clinics in these efforts and specifically highlights the need to screen for violence during HIV pre- and posttest counseling.

Stigma toward HIV and people with HIV is widespread among Mexican health care providers (Infante et al., 2006). Discrimination against Mexican women with HIV in health care settings is often related to seeking sexual and reproductive health services, and thus has an important gender dimension (Kendall, 2009b). Most of our sample (60.8%) reported HIV-related discrimination from health care providers, and we found a significant association between this discrimination and reporting psychological violence as a result of disclosure. Research with women of unknown HIV status has shown that trusting health care providers and perceiving them as attentive and nonjudgmental are important factors in women's decisions to disclose experiences of violence (Robinson & Spilsbury, 2008). For Mexican immigrants, women of Mexican descent, and other Latinas, the quality of the interpersonal relationship with health care providers has been found to be particularly relevant to whether or not women choose to disclose violence (Montalvo-Liendo, 2009). Experiences of HIV-related discrimination are likely to negatively impact women's willingness to disclose violence and seek support in the health care setting. Health professionals must change their discriminatory behaviors to create the conditions of trust necessary to effectively identify and respond to violence against women with HIV.

The Mexican government has made significant efforts to create HIV clinics that are free from homophobia and discrimination related to sexual orientation. Actions have included informing health service users about their rights to receive services free from discrimination based on sexual orientation, providing mechanisms for lodging complaints, and inculcating acceptance of people with diverse sexual orientations among HIV health care providers through workshops and other education opportunities (CENSIDA, 2009a). Programs to address the gender discrimination faced by women with HIV are also needed in Mexican HIV care. Within this context, addressing violence against women must be a priority.

The proportion of women in our sample who reported lifetime sexual violence (29.2%) was higher than the 17.3% found in a representative survey of Mexican women accessing health services (Olaiz et al., 2006). This finding may point to the importance of implementing existing legally mandated clinical guidelines to provide postexposure HIV prophylaxis to survivors of sexual violence as part of a comprehensive HIV prevention strategy (Secretaria de Salud, 2009).

Violence Against Women, Women's Autonomy, and Social Support in Cultural Context

Our analysis found statistically significant associations between women having experienced physically forced sexual intercourse during their lifetimes and factors that could be interpreted as markers of women's increased autonomy: (a) living alone or with nonfamily members, (b) making a monetary contribution to the household income, and (c) describing their occupations as something other than housewife. A nationally representative cross-section household study of Mexican women from the general population also identified a link between women's work outside of the home and intimate partner violence (Castro, Casique, & Brindis, 2008). The fact that both our study and this larger study were cross-section surveys did not allow for identification of causal or temporal links between employment and violence. Possible hypotheses to explain the counterintuitive association between women making a monetary contribution to the household and experiences of violence include men feeling

threatened by women's economic independence, spousal conflict arising from women's double or triple shift as they engage in both paid and domestic labor, or women seeking paid work as part of an exit strategy from a violent relationship (Castro et al., 2008).

It is relevant to note that in the Mexican context, sources of social support, such as the family, may actually reinforce and justify violence against women for perceived transgressions of gender role expectations (Agoff, Herrera, & Castro, 2007). Longitudinal surveys and qualitative research are needed to explain these relationships among women from the general population and women with HIV. Meanwhile, nurses and other health care providers should exercise sensitivity when exploring experiences of violence and women's social networks. Health care providers' membership in the larger culture means that nurses and other health professionals need training that addresses both personal attitudes and professional obligations in order to allow them to exercise sensitivity and self-awareness when exploring gender norms, violence against women, family dynamics, and sources of social support for women (Agoff et al., 2007; Castro et al., 2008; Herrera et al., 2006; Kim & Motsei, 2002).

Limitations

Our results draw on a small convenience sample of Mexican women with HIV, and caution should be exercised in drawing general conclusions. The women with HIV who participated in this workshop may have been qualitatively different from women who were not invited to participate, women who were invited to participate but did not attend, and women with HIV who do not have contact with health services or civil-society networks and thus were not known to the workshop organizers. This cross-sectional study did not allow us to infer causality between experiencing forced sexual intercourse at some point in their lives and currently living alone or with nonfamily members, nor to explain the relationship between experiencing psychological violence as a result of disclosing HIV status and living alone or with nonfamily members. We found statistically significant associations between women's living situations, economic contributions to the household, and experiences of violence, but our results should be interpreted tentatively as the absolute numbers of women on which these observations were based was small. Finally, we did not collect information about who perpetrated violence against women as a consequence of disclosure of HIV status and are unable to identify whether this violence came from health care providers, male partners, family members, or others. Future research should identify the perpetrators of violence against women with HIV and the contexts in which this violence occurs, as these findings would be clinically relevant.

Conclusions

The rates of past and current violence in the lives of these women with HIV, and their experiences of physical and psychological violence as a consequence of sharing an HIV diagnosis, suggest that screening for violence as part of pre and posttest HIV counseling and addressing violence as a routine part of HIV treatment and care is ideal to support safe disclosure of the HIV diagnosis and improve the quality of life of women with HIV. This study also found that women with HIV frequently feel discriminated against by health care providers and found an association between reporting HIV-related discrimination from health care providers and psychological violence as a consequence of disclosing an HIV diagnosis. Our findings lead us to reiterate other researchers' calls for HIV care providers to improve their abilities to identify and respond to gender-based violence in the context of HIV testing and HIV care, in part through integration of clinical protocols and cross-reference with violence services (Gielen et al., 2000; Maman & Medley, 2003). The capacity and commitment of nurses and other health care providers to identify and respond appropriately to past and current violence experienced by Mexican women with HIV could be strengthened by trainings that address gender-specific forms of HIV discrimination, critically analyze cultural norms that uphold gender-discrimination (including violence against women), and update health care providers on existing Mexican antiviolence legislation. To increase success, these trainings should provide opportunities to deconstruct

personal and cultural beliefs about violence against women and HIV among women, as well as communicating information about professional obligations and health care protocols (Herrera et al., 2006; Kendall, 2009a, 2009b; Kim & Motsei, 2002; Maman & Medley, 2003; Montalvo-Liendo, 2009).

Clinical Considerations

- Screening for violence should be a routine part of the post-test HIV counseling protocol.
- Violence against women must be addressed as a routine part of the treatment and care of women with HIV.
- Recognition and understanding of gender discrimination and violence against women must be strengthened in ongoing training for health care providers. Eliminating HIV-related discrimination by health care providers is necessary to create a safe environment for disclosure of experiences of violence and allow appropriate referrals.
- It is important to implement health care guidelines that would provide HIV post-exposure-prophylaxis to survivors of sexual violence.

Disclosures

The authors report no real or perceived vested interests that relate to this article (including relationships with pharmaceutical companies, biomedical device manufacturers, grantors, or other entities whose products or services are related to topics covered in this manuscript) that could be construed as a conflict of interest.

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References

Agoff, C., Herrera, C., & Castro, R. (2007). The weakness of family ties and their perpetuating effects on gender violence: A qualitative study in Mexico. *Violence Against Women*, *13*, 1206-1220. doi:10.1177/1077801207307800

Barros, C., Schraiber, L. B., & Franca-Junior, I. (2011). Association between intimate partner violence against women and HIV infection. *Revista de Saude Publica*, *45*, 365-372. doi:10.1590/S0034-89102011005000008

Campbell, J. C., Baty, M. L., Ghandour, R. M., Stockman, J. K., Francisco, L., & Wagman, J. (2008). The intersection of intimate partner violence against women and HIV/AIDS: A review. *International Journal of Injury Control and Safety Promotion*, *13*, 221-231. doi:10.1080/17457300802423224

Campero, L., Herrera, C., Kendall, T., & Caballero, M. (2007). Bridging the gap between antiretroviral access and adherence in Mexico. *Qualitative Health Research*, *17*, 599-611. doi:10.1177/1049732307301335

Castro, R., Casique, I., & Brindis, C. D. (2008). Empowerment and physical violence throughout women's reproductive life in Mexico. *Violence Against Women*, *14*, 655-677. doi:10.1177/1077801208319102

Centro Nacional Para la Prevención y el Control del VIH/SIDA. (2009a). *Estrategia de sensibilización: CAPASITS libres de homofobia y discriminación [Education strategy: CAPASITS free of homophobia and discrimination]* (2nd ed.). Retrieved from http://www.censida.salud.gob.mx/interior/biblioteca/capasitslibres.html

Centro Nacional Para la Prevención y el Control del VIH/SIDA. (2009b). *El VIH/SIDA en México 2009 [HIV/AIDS in Mexico 2009]*. Mexico City, Mexico.

Consejo Nacional de Evaluacion de la Politica de Desarrollo Social. 2011. *Measurement: Frequently Asked Questions*. Mexico City, Mexico: Author. Retrieved from http://www.coneval.gob.mx/cmsconeval/rw/pages/medicion/faq.en.do

De Luca, M., Rodriguez-Magis, C., Bravo-Garcia, E., Rivera-Reyes, P., Ortiz-Mondragon, R., & Gayet, C. (2010). La epidemia de SIDA en México al 2008 [The Mexican AIDS epidemic in 2008]. *Gaceta Médica de México*, *146*(1), 45-49.

Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntyre, J. A., & Harlow, S. D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet*, *363*, 1415-1421. doi:10.1016/S0140-6736(08)61345-8

Gielen, A. C., McDonnell, K. A., Burke, J. G., & O'Campo, P. (2000). Women's lives after an HIV-positive diagnosis:

Disclosure and violence. *Maternal and Child Health Journal*, *4*, 111-120. doi:10.1023/A:1009522321240

Gonzalez-Guarda, R., Peragallo, N., Urrutia, M. T., Vasquez, E. P., & Mitrani, V. B. (2008). HIV risks, substance abuse, and intimate partner violence among Hispanic women and their intimate partners. *Journal of the Association of Nurses in AIDS Care*, *19*, 252-266. doi:10.1016/j.jana.2008.04.001

Heise, L. L. (1998). Violence against women: An integrated ecological framework. *Violence Against Women*, *4*, 262-290. doi:10.1177/1077801298004003002

Herrera, C., & Campero, L. (2002). La vulnerabilidad e invisibilidad de las mujeres ante el VIH/SIDA: Constantes y cambios en el tema [The vulnerability and invisibility of women facing HIV/AIDS: Constant and changing issues]. *Salud Publica de Mexico*, *44*(6), 554-564.

Herrera, C., Rajsbaum, A., Agoff, C., & Franco, A. (2006). Entre la negación y la impotencia: Prestadores de servicios de salud ante la violencia contra las mujeres en México [Between denial and helplessness: Health care providers facing domestic violence in Mexico]. *Salud Pública de México*, *48*(Suppl. 2), S259-S267.

Instituto Nacional de Estadistica y Geografia. (2006). *Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares 2006, Tabulados básicos-descarga. Tema: Violencia de pareja [National Survey on Household Relationship Dynamics 2006, Basic tables-download. Subject: Partner violence]*. Aguascalientes, Mexico: Author. Retrieved from http://www.inegi.org.mx/sistemas/tabuladosbasicos2/TabGeneral.aspx?s=est&c=26245

Instituto Nacional de Estadistica y Geografia. (2009). *El INEGI da a conocer los resultados de la Encuesta Nacional de Ingresos y Gastos de los Hogares (ENIGH) 2008. Comunicado numero 191/09, 16 de Julio de 2009 [INEGI presents the results of the National Survey on Household Income and Spending (ENIGH) 2008. Press release number 191/09, July 16, 2009]*. Aguascalientes, Mexico: Author. Retrieved from http://www.inegi.org.mx/inegi/contenidos/espanol/prensa/comunicados/enigh2008.asp

Infante, C., Zarco, A., Cuadra, S., Morrison, K., Caballero, M., Bronfman, M., & Magis, C. (2006). El estigma asociado al VIH/SIDA: El caso de los prestadores de servicios de salud en México [HIV/AIDS-related stigma and discrimination: The case of health care providers in Mexico]. *Salud Pública de México*, *48*(2), 141-150.

Joint United Nations Programme on HIV/AIDS. (2010a). *Report on the global HIV/AIDS epidemic 2010*. Geneva, Switzerland: Author. Retrieved from http://www.unaids.org/globalreport/

Joint United Nations Programme on HIV/AIDS. (2010b). *Women, girls and HIV fact sheet*. Geneva, Switzerland: Author. Retrieved from http://data.unaids.org/pub/FactSheet/2010/20100302_fs_womenhiv_en.pdf

Kendall, T. (2009a). La vulnerabilidad de las mujeres mexicanas frente al VIH y el sida [Mexican women's vulnerability to HIV and AIDS]. In C. Magis-Rodríguez, & H. Barrientos Bárcenas (Eds.), *VIH/SIDA y salúd pública: Manual para personal de salud* (pp. 149-160). Mexico City, Mexico: CENSIDA/INSP.

Kendall, T. (2009b). Reproductive rights violations reported by Mexican women with HIV. *Health and Human Rights: An International Journal*, *11*(2), 79-89.

Kim, K., & Motsei, M. (2002). "Women enjoy punishment": Attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Social Science & Medicine*, *54*, 1243-1254. doi:10.1016/S0277-9536(01)00093-4

Krishnan, S., Dunbar, M. S., Minnis, A. M., Medlin, C. A., Gerdts, C. E., & Padian, N. S. (2008). Poverty, gender inequities, and women's risk of human immunodeficiecy virus/AIDS. *Annals of the New York Academy of Science*, *1136*, 101-110. doi:10.1196/annals.1425.013

Maman, S., & Medley, A. (2003). *Gender dimensions of HIV status disclosure to sexual partners: Rates, barriers and outcomes for Women. A review paper.* Geneva, Switzerland: World Health Organization. Retrieved from http://www.who.int/gender/documents/en/genderdimensions.pdf

Manfrin-Ledet, L., & Porche, D. J. (2003). The state of science: Violence and HIV infection in women. *Journal of the Association of Nurses in AIDS Care*, *14*, 56-68. doi:10.1177/1055329003252056

Miner, S., Ferrer, L., Cianelli, R., Bernales, M., & Cabieses, B. (2011). Intimate partner violence and HIV risk behaviors among socially disadvantaged Chilean women. *Violence Against Women*, *17*, 517-531. doi:10.1177/1077801211404189

Montalvo-Liendo, N. (2009). Cross-cultural factors in disclosure of intimate partner violence: An integrated review. *Journal of Advanced Nursing*, *65*, 20-34. doi:10.1111/j.1364-2648.2008.04850.x

Olaiz, G., Rico, B., & Del Rio, A. (2003). *Encuesta nacional sobre violencia contra las mujeres* [*National survey on violence against women*]. Cuernavaca, Morelos: Instituto Nacional de Salud Pública. Retrieved from http://www.mujerysalud.gob.mx/mys/doc_pdf/encuesta.pdf

Olaiz, G., Rojas, R., Valdez, R., Franco, A., & Palma, O. (2006). Prevalencia de diferentes tipos de violencia en usuarias del sector salud en México [Gender violence prevalence in female users of health services in Mexico]. *Salud Publica de México*, *48*(Suppl. 2), S232-S238.

Raj, A., Santana, C., La Marche, A., Amaro, H., Cranston, K., & Silverman, J. G. (2006). Perpetration of intimate partner violence associated with sexual risk behaviors among young adult men. *American Journal of Public Health*, *96*, 1873-1878. doi:10.2105/AJPH.2005.081554

Robinson, L., & Spilsbury, K. (2008). Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence. *Health and Social Care in the Community*, *16*, 16-30. doi:10.1111/j.1365-2524.2007.00721.x

Secretaria de Salud. (1999). *NORMA Oficial Mexicana NOM-190-SSA1-1999, Prestación de servicios de salud. Criterios para la atención médica de la violencia familiar [Official Mexican guideline for providing health services NOM-190-SSA1-1999. Criteria for medical care for family violence*.

Mexico City, Mexico: Author. Retrieved from http://www.salud.gob.mx/unidades/cdi/nom/190ssa19.html

Secretaria de Salud. (2009). *NORMA Oficial Mexicana NOM-046-SSA2-2005. Violencia familiar, sexual y contra las mujeres. Criterios para la prevención y atención [Official Mexican guideline NOM-046-SSA2-2005. Sexual and family violence against women. Criteria for prevention and care]*. Mexico City, Mexico: Author. Retrieved from http://www.gobernacion.gob.mx/work/models/SEGOB/Resource/689/1/images/VIOLE1B.PDF

Semrau, K., Kuhn, L., Vwalika, C., Kasonde, P., Sinkala, M., Kankasa, C., … Thea, D. M. (2005). Women in couples antenatal HIV counselling and testing are not more likely to report adverse social events. *AIDS*, *19*(6), 603-609.

Silverman, J. G., Decker, M. R., Saggurti, N., Balaiah, D., & Raj, A. (2008). Intimate partner violence and HIV infection among married Indian women. *JAMA*, *300*(6), 703-710.

Silverman, J. G., Decker, M. R., Kapur, N. A., Gupta, J., & Raj, A. (2007). Violence against wives, sexual risk and sexually transmitted infection among Bangladeshi men. *Sexually Transmitted Infections*, *83*, 211-215. doi:10.1136/sti.2006.023366

Wiedel, J. J., Provencio-Vazquez, E., Watson, S. D., & Gonzalez-Guarda, R. (2008). Cultural considerations for intimate partner violence and HIV risk in Hispanics. *Journal of the Association of Nurses in AIDS Care*, *19*, 247-251. doi:10.1016/j.jana.2008.05.001