
Domestic Violence Shelters as Prevention Agents for HIV/AIDS?

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The article reports findings from a pilot study of 21 domestic violence shelters in a southwestern state in the United States. The survey instrument included descriptive information on shelter service delivery. Specifically, questions were asked about the practice of assessing a client's risk of HIV/AIDS, the provision of HIV/AIDS educational and prevention programs within shelters, and information about organizational characteristics that facilitate or impede the existence of these services. The findings suggest that shelters lacked sufficient HIV/AIDS policies and programs to respond to their client's heightened risk of infection. Although 19 (90.5 percent) of the shelters reported that they routinely ask about their clients' sexual abuse histories, there was no link between a woman's disclosure of sexual abuse and a subsequent provision of appropriate HIV/AIDS services (referrals for testing, treatment) by the shelter. HIV/AIDS awareness was high among the shelter staff who responded to the survey, but HIV/AIDS prevention and education were practically nonexistent. Implications for social work practice are discussed.

KEY WORDS: *domestic violence shelters; education; HIV/AIDS; prevention; risk assessment*

Women are at a heightened risk of experiencing two prominently positioned public health concerns: intimate partner abuse (IPA) and HIV/AIDS. Women are far more likely than men to be raped or physically assaulted by an intimate partner, with seven out of 10 women being raped or assaulted by an intimate partner, friend, or acquaintance (Bureau of Justice Statistics, 2005). Between 1976 and 2004, 51.9 percent of all female homicides were committed by intimate partners or acquaintances (Catalano, 2006). Intimate partner violence constituted 22 percent of all violent crimes against women between the years 1993 and 2004 (Catalano, 2006).

Since the first diagnosis of HIV in 1981, the number of women infected with the disease tripled from 8 percent in 1985 to 27 percent in 2004 (Centers for Disease Control and Prevention [CDC], 2007). In fact, the CDC reports that if trends continue, women will outnumber men with this disease in the near future. In addition, in 2004, an estimated 80 percent of all women with AIDS were women of color (CDC, 2007). A report by UNAIDS (2006) stated the following:

In the U.S., AIDS is the leading cause of death among African-American women ages 25 to 34, with AIDS rates among Hispanic women rapidly on the rise. Although many factors contribute to these trends, the majority of women who are HIV-infected—or at great risk—do not practice “high-risk” behavior. Women and girls are vulnerable largely because of the behavior of others—too often lacking not just information, but the social and economic power to control their bodies and their lives. (p. 2)

Consequently, research suggests that the disproportionate rates of women contracting HIV/AIDS may be explained in part by the intersection between IPA and HIV/AIDS, whereby sexual and physical violence toward women affects the likelihood of transmission (Beadnell, Baker, Morrison, & Knox, 2000; Eby, Campbell, Sullivan, & Davidson, 1995; El-Bassel et al., 1998; Gielen, McDonnell, Burke, & O'Campo, 2000; He, McCoy, Stevens, & Stark, 1998; Liebschutz, Feinman, Sullivan, Stein, & Samet, 2000; North & Rothenberg, 1993; Wingood, DiClemente, & Raj, 2000). Women who have a history of both

sexual and physical abuse by intimate partners are more than three times as likely to report having a sexually transmitted disease (STD) during the abusive relationship, 5.6 times more likely to report having multiple STDs, and 5.3 times more likely to report having an STD over the past two months. In addition, sexually and physically abused women are 2.7 times more likely to worry about acquiring HIV (Wingood et al., 2000). This research suggests that women in abusive relationships need information about how to keep themselves safe from infection.

Women who have experienced intimate partner abuse often seek refuge from domestic violence (DV) shelters. Because DV shelters are a social service entry point for women seeking a violence-free environment, several researchers (El-Bassel et al., 1998; He et al., 1998; Molina & Basnait-Smith, 1998; Wingood et al., 2000) recommended that these shelters operate as a venue for assessing a client's risk of HIV/AIDS and provide HIV/AIDS education and prevention information. The current study investigated the presence or absence of HIV/AIDS services in DV shelters within a southwestern state. What is not apparent in the literature is whether DV shelters, a primary entry point for women experiencing intimate partner abuse seeking support and services, provide HIV/AIDS services. The findings of this research study will inform structural recommendations for DV shelters inclusive of their client's heightened risk of infection. On the basis of these findings, recommendations are made to integrate risk assessment, HIV/AIDS education and prevention information into shelter policies, procedures, and the service delivery protocols.

The purpose of this pilot investigative study was to examine the provision of HIV/AIDS services in DV shelters. The three primary research questions were as follows:

To what extent do domestic violence shelters assess a women's risk for HIV/AIDS upon admission?

To what extent do domestic violence shelters provide prevention and education counseling regarding HIV/AIDS to women who have experienced intimate partner violence?

If domestic violence shelters are not providing HIV/AIDS assessment, education, and prevention, what are some of the primary reasons given for the lack of services?

METHOD

Sampling Procedures

Shelters were identified from a list compiled by a local Coalition against Domestic Violence, an advocacy organization in the state. This research study was conducted in one state only because of the pilot nature of this project and the manageable collection of data. A staff member at each of the state's 33 shelters was identified by the researchers. These shelter representatives had to have worked at the shelter for at least a year and reported that they felt knowledgeable enough about the shelter's practices and policies to complete the survey. The research team explained to each participant the purpose of the study, assurances of confidentiality, and reported, as a way of motivating timely participation, that a \$500 donation would be given to one randomly selected, participating shelter whose representative returned his or her survey within a two-week period. A follow-up e-mail or written letter restating this information, along with the self-administered questionnaire, was sent to the selected representatives of all the shelters. Twelve (36 percent) shelters returned their surveys within two weeks. Researchers contacted by phone the shelters that had not yet returned the survey, encouraged the representatives to return their survey, and offered to answer any questions related to the study. No substantive differences were found between those shelters that responded within two weeks and those shelters that responded after phone contact. Ultimately, 21 shelters returned surveys, for a final response rate of 64 percent.

Of the 21 shelter representatives, eight (38 percent) reported feeling "very knowledgeable" about the agency's practices and policies related to HIV/AIDS, five (24 percent) reported feeling "semiknowledgeable," six (28 percent) reported feeling "somewhat knowledgeable," and two (10 percent) reported feeling "semi- not knowledgeable." Representatives held an array of roles within their respective shelters: program coordinator (7), executive director (5), case manager (3), counselor (1), or some other role (5). Those participants who indicated "some other role" provided community outreach services and public education. On average, respondents had worked for their respective shelters for five years.

Measures

Geographic setting was measured by respondents' report of the geographic location of the shelter: rural

($n = 12$), suburban ($n = 3$), or urban ($n = 6$). The range of services was captured by respondents' indication of whether the shelter provided any of 17 services (1 = yes, 0 = no), (for example, case management, paid HIV testing, free HIV testing). These items were summed; higher scores indicated a higher number of services provided. The proportion of clients of color was measured on the basis of respondents' estimates of the percentage of the clients served by race or ethnicity: Black/African American, Hispanic/Latina, Native American, Caucasian/White, Asian/Pacific Islander, and Other.

Shelter procedures related to HIV/AIDS programming and agency protocols and practice were also measured; in addition, we asked respondents to indicate (1 = yes, 0 = no) whether shelter staff members routinely ask clients about their sexual abuse histories, especially within their relationships. This scale had high internal consistency ($\alpha = .79$). To measure shelter personnel's beliefs, we asked respondents to indicate the degree to which they believed HIV/AIDS prevention programs are effective in protecting abused women from contracting HIV/AIDS on a four-point scale, with 1 = very ineffective, 2 = somewhat ineffective, 3 = somewhat effective, and 4 = very effective. Shelter leaders' knowledge of HIV/AIDS was measured by the sum of total correct answers to 26 questions assessing respondent's knowledge of HIV/AIDS rates of infection and transmission. These questions included the 18 items in the HIV Knowledge Questionnaire, which has been shown to have high reliability (Carey & Schroder, 2002). Higher scores indicated a greater knowledge of HIV/AIDS. Eight items were added to the existing measure of HIV knowledge developed from existing research studies, specifically related to HIV/AIDS prevalence statistics (that is, HIV/AIDS infection rates among women, monetary resources for education, prevention, and treatment of the disease). The eight items were different from the 18 original questions, lowering the internal reliability coefficient ($\alpha = .10$).

A shelter's provision of HIV/AIDS services was measured by the sum of responses to 10 questions about the shelter's offering of HIV/AIDS prevention programming and the existence of shelter HIV/AIDS-related practices or policies. Examples included whether shelters have a nondiscrimination policy that protects HIV-positive clients and employees, staff training on HIV/AIDS prevention, and guidelines for confidentiality protection if a client

should disclose having HIV/AIDS. This scale had high internal consistency ($\alpha = .81$). Higher scores indicated a higher number of HIV/AIDS services at the shelter. A modified measure of shelter HIV/AIDS services was constructed by adding to the previous measure an item that captured whether shelter staff members routinely ask clients about their sexual abuse histories.

The impediments to offering HIV/AIDS prevention information and education as part of service delivery were measured with six items that were developed from an analysis of qualitative interviews with executive directors of DV shelters that constituted a separate research project. The questions were measured using a five-point Likert scale ranging from 1 = strongly agree to 5 = strongly disagree. The questions were related to the areas of budgetary constraints, lack of training, partnerships with other agencies, lack of funding support for prevention and education efforts, scheduling priorities, and the need for additional staff.

Seven items were developed related to why shelters may not assess a client's risk of HIV/AIDS as part of the delivery of services. The questions were measured using a five-point Likert scale ranging from 1 = strongly agree to 5 = strongly disagree. The questions were related to the areas of fear of litigation, need for intake restructuring, need for additional training, financial resources, discrimination and confidentiality issues, client reluctance to disclose, and clients' emotional stability.

Data Analysis

Analysis of survey data included frequency distributions and reliability analyses. Closed-ended items were analyzed using the SPSS (Version 11.5) (SPSS Inc., 2002).

FINDINGS

Shelter Characteristics

Most of the shelters that were solicited for participation were in rural locations ($n = 17$), followed by suburban ($n = 10$) and urban locations ($n = 6$). Urban shelters had the highest response rate (100 percent, $n = 6$), followed by rural shelters (70 percent, $n = 12$) and suburban shelters (30 percent, $n = 3$). On average, shelters had been in operation for approximately 12 years. Two shelters had operated between one to five years, four between six to 10 years, and three between 11 to 15 years. The remaining 12 shelters had operated for 16 years or

more. On average the shelters reported 11 full-time employees, five part-time employees, and 23 volunteers. On average 24 percent of the clients served were between ages 18 and 25 years, 32 percent were between ages 26 and 35 years, 29 percent were between ages 36 and 46 years, and 15 percent were between ages 47 and 56. The majority of clients served were white (42 percent), though there were also a large percentage of Hispanic/Latina clients (28 percent). Smaller percentages of clients were black/African American (8 percent), Native American (18 percent), Asian/Pacific Islander (3 percent), and other (1 percent).

Service Delivery

The types of services provided by the shelters are presented in Table 1.

The number of services offered ranged from nine to 16, with a mean of 12.7 ($SD = 2.12$). All shelters provided case management, advocacy, volunteer opportunities, and emergency shelter (see Table 1). Fewer than half of the shelters provided the following four services: lending library (38.1 percent), paid HIV testing (0 percent), free HIV testing (9.5 percent), and permanent housing (9.5 percent). Therefore, the services most frequently offered by shelters appear to be either interim or crisis-oriented

Table 1: Frequencies of Types of Services Provided by Domestic Violence Shelters (N = 21)

Service	(%) Yes	(%) No
Crisis hot line	90.5	9.5
Individual counseling	71.4	28.6
Group counseling	90.5	9.5
Case management (Resource and referral)	100	
Public education	85.7	14.3
Advocacy	100	
Transportation	76.2	23.8
Lending library	38.1	61.9
Paid HIV testing		100
Free HIV testing	9.5	90.5
Children's services	81	19
Youth services	61.9	38.1
Transitional housing	76.2	23.8
Permanent housing	9.5	90.5
Volunteer opportunities	100	
Emergency shelter	100	
Community presentations	85.7	14.3

services that address primarily DV issues rather than services that attend to the potential risk factors that might be a consequence of the violence.

Participant Awareness

The data in Table 2 show the respondents' largest number of correct responses related to HIV/AIDS transmission and populations most at risk of infection; 75 percent of the respondents answered 24 (92 percent) of the 26 questions correctly. Unexpectedly, six (29 percent) of the respondents were not aware that there is a female condom that can help decrease a woman's chance of getting HIV. In addition, 10 (52 percent) of the respondents answered incorrectly that infant females account for the highest number of female HIV/AIDS cases. In general, the respondents seemed to have a good understanding of the effect of HIV/AIDS on women; however, there did not appear to be a translation of this knowledge into shelter services. In addition, although respondents understood the HIV/AIDS risk factors for women, they did not seem to recognize the link between HIV/AIDS risk and domestic violence.

Sexual Assault Assessment Related to HIV/AIDS Risk

Nineteen (90.5 percent) of the respondents reported that the shelters routinely ask clients whether they have been sexually abused in their relationship. As part of the intake process, respondents cast a broad net to inquire about the magnitude of the abuse (sexual, physical, verbal, psychological, emotional, and economic). This finding indicates that DV shelters have information about a woman's sexual assault from an intimate partner; however, the risk for HIV/AIDS, given this history, is not explored relative to testing or prevention.

HIV/AIDS PREVENTION PROGRAMMING

In response to questions about whether HIV/AIDS prevention programs could be effective in protecting abused women from contracting HIV/AIDS, 15 (71.4 percent) of the respondents felt HIV/AIDS educational prevention programs would be "somewhat effective" in protecting abused women from contracting HIV/AIDS. Three (14.3 percent) respondents believed such programming could be "very effective," two (9.5 percent) indicated "somewhat ineffective," and one (4.8 percent) respondent answered "very ineffective." Therefore, 18 (85.7 percent) of the 21 respondents stated that they felt

Table 2: Percentage of Correct Responses: Knowledge of HIV/AIDS Rates of Infection and Transmission

Statement	% Correct Response
*Women represent the most rapidly increasing category of individuals with HIV/AIDS.	81 (T)
*Compared with adult and adolescent rates of female HIV/AIDS infection, infant females account for the highest number of female HIV/AIDS cases.	52.4 (F)
*Among women of color, African American and Latina women are the fastest growing infected population.	81.0 (T)
*Economically disadvantaged women's rates of infection are stable.	90.5 (F)
*Lack of monetary resources and attention to HIV/AIDS education and prevention for women is a barrier to reducing women's risks for HIV/AIDS infection.	85.7 (T)
*Lack of monetary resources and attention to HIV/AIDS treatment advances for women is a barrier to reducing women's risk of HIV/AIDS infection.	85.7 (T)
*The total cost of health care of the most common STDs, including resulting complications, is estimated conservatively at \$17 billion annually.	100 (T)
*In light of recent advances in HIV diagnostics and therapies, the lifetime costs of health care associated with HIV infection is \$155,000 or more per person.	90.5 (T)
Coughing and sneezing DO NOT spread HIV.	90.5 (T)
A person can get HIV by sharing a glass of water with someone who has HIV.	81.0 (F)
Pulling out the penis before a man climaxes keeps a women from getting HIV during sex.	100 (F)
A woman can get HIV if she has anal sex with a man.	85.7 (T)
Showering or washing one's genitals/private parts, after sex keeps a person from getting HIV.	100 (F)
All pregnant women infected with HIV will have babies born with AIDS.	90.5 (F)
People who have been infected with HIV quickly show serious signs of being infected.	76.2 (F)
There is a vaccine that can stop adults from getting HIV.	100 (F)
People are likely to get HIV by deep kissing (putting their tongue in their partner's mouth) if their partner has HIV.	76.2 (F)
A woman cannot get HIV if she has sex during her period.	100 (F)
There is a female condom that can help decrease a woman's chance of getting HIV.	71.4 (T)
A natural skin condom works better against HIV than does a latex condom.	85.7 (F)
A person will not get HIV if she or he is taking antibiotics.	90.5 (F)
Having sex with more than one partner can increase a person's chance of being infected with HIV.	90.5 (T)
Taking a test for HIV one week after having sex will tell a person if she or he has HIV.	90.5 (F)
A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.	90.5 (F)
A person can get HIV from oral sex.	100 (T)
Using Vaseline or baby oil with condoms lowers the chance of getting HIV.	95.2 (F)

Note: T = true, F = false. STDs = sexually transmitted diseases.

*Items developed from existing research studies.

that HIV/AIDS prevention programs would be effective in prevention of this illness among women who have experienced IPA. Although the majority of respondents believe that HIV/AIDS prevention programs would be beneficial to this population of women, few of the shelters currently offer these services.

Shelter Implementation: HIV/AIDS Programming

In response to questions about the shelters' provision of HIV/AIDS prevention programming, three respondents (14.3 percent) reported that as part of their agency's HIV/AIDS services, staff are trained about a women's risk of acquiring STDs. Only

five respondents (23.8 percent) reported that staff members counsel clients about methods of STD prevention and treatment. In addition, four respondents (19.0 percent) reported that staff speak with clients about HIV risk reduction strategies. Only one reported (4.8 percent) that HIV/AIDS prevention was part of the safety planning process that is completed with clients. The mean was 4.9 ($SD = 2.78$), and the range was from 1 to 10.

Agency Protocols and Practice

Regarding shelter protocols and practices, 18 respondents (85.7 percent) reported that their shelters have a nondiscrimination policy that protects HIV-positive clients and employees. Six respondents

(28.6 percent) reported that their shelter offers staff training on HIV/AIDS prevention. In addition, 16 respondents (76.2 percent) reported having guidelines for confidentiality protection if a client should disclose having HIV/AIDS. Only 10 of the respondents (47.6 percent) reported that their shelters have counseling guidelines for women who have experienced IPA and express concerns about HIV infection for themselves and their partners. Also, 18 (85.7 percent) reported providing referrals to clients for statewide resources, including HIV/AIDS counseling, testing, and treatment services. Fifteen respondents (71.4 percent) reported having safety procedures at their shelters to protect staff and residents from accidental HIV/AIDS exposure. In addition, eight of the shelters (38 percent) disseminate HIV/AIDS information to all women in the shelter. Only six respondents (28.6 percent) participate in community working groups that share information related to the integration of HIV/AIDS risk assessment at intake. Six of the respondents (28.6 percent) participate in community working groups that share information related to the integration of HIV/AIDS prevention into shelter service. Scale scores ranged from 2 to 11, and the mean was 5.8 ($SD = 2.8$).

Overall, the administrative functioning of shelters appears to conform to federal guidelines regarding people with disabilities (that is, confidentiality); however, the shelters do not seem to attend to the prevention of the disease.

Impediments to the Integration of HIV/AIDS Services into Shelter Services

Respondents varied in the degree to which they believed certain reasons were impediments to shelters assessing a client's risk of HIV/AIDS. Ten (48 percent) respondents indicated staff would

need additional training, and 12 (57.2 percent) respondents cited inadequate financial resources (see Table 3). Eight (38 percent) indicated the possibility that clients would not honestly share information about their abuse history and infection risk. Table 4 shows respondents' degree of agreement with a list of reasons why shelters may not offer HIV/AIDS prevention as part of service delivery. Participants reported that they "strongly agree" and "agree" about five organizational impediments: Fifteen (71.4 percent) respondents cited budgetary constraints. Eighteen (79.7 percent) respondents indicated absence of expertise among staff. In addition, 11 (52.4 percent) cited lack of an interdisciplinary or collaborative approach as a barrier. Also, 13 (61.9 percent) respondents believed that HIV/AIDS programs are not a scheduling priority for the agency, and 12 (57.2 percent) respondents believed the need for additional staff is an impediment to the integration of HIV/AIDS.

DISCUSSION

Shelters lack HIV/AIDS programming to meet the needs of the women they serve who are at increased risk of HIV/AIDS infection. Given the empowerment model used by this southwestern state, these services are only offered if a client specifically requests them in contrast to immediately linking those who disclose sexual abuse and increased risk of infection with information about testing, treatment, and risk reduction strategies. Perhaps this definition of empowerment is too narrowly defined and should be elevated to include a woman's right to information about her heightened risk of disease given her history of sexual assault or abuse. In addition, women could be empowered to make informed decisions about their health and well-being if provided with prevention and educational

Table 3: Reasons Why Shelters May Not Assess a Client's Risk of HIV/AIDS

Reason	Strongly Agree		Agree		Neither Agree Nor Disagree		Disagree		Strongly Disagree	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Litigation	1	4.8	2	9.5	9	42.9	2	9.5	7	33.3
Intake	2	9.5	4	19.0	4	19.0	5	23.8	6	28.6
Training	5	23.8	5	23.8	2	9.5	6	28.6	3	14.3
Budget	6	28.6	3	14.3	3	14.3	3	14.3	3	14.3
Bias	1	4.8	2	9.5	3	14.3	10	47.6	5	23.8
No disclosure	4	19.0	4	19.0	6	28.6	4	19.0	3	14.3
Emotionality	3	14.3	2	9.5	7	33.3	5	23.8	4	19.0

Table 4: Reasons Why Shelters May Not Offer HIV/AIDS Prevention and Education Programs

Reason	Strongly Agree		Agree		Neither Agree Nor Disagree		Disagree		Strongly Disagree	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Budget constraints	7	33.3	8	38.1	3	14.3	2	9.5	1	4.8
Staff need training	6	28.6	12	57.1	2	9.5	1	4.8		
Need agency partners	2	9.5	9	42.9	7	33.3	2	9.5	1	4.8
Lack funds for prevention efforts	8	38.1	6	28.6	6	28.6	1	4.8		
Scheduling difficulty	3	14.3	10	47.6	6	28.6	2	9.5		
Need additional staff	3	14.3	9	42.9	4	19.0	3	14.3	2	9.5

programs while residing at DV shelters. By talking to their legislators, shelter directors could advocate for funding of such programs by raising the issue of the cost-effectiveness to the state for wraparound prevention programs.

The vast majority of respondents (90 percent) reported at the end of the survey that the survey encouraged their thinking about HIV/AIDS risk assessment and prevention and broadened their perspectives related to HIV/AIDS risk assessment and prevention and education. The respondents provided insight into impediments to the assessment of a client's risk of HIV/AIDS. Organizational characteristics that were identified included the need to restructure the intake process, the need for additional staff training, inadequate financial resources, the emotional unreadiness of clients to disclose, and belief that clients would not share the truth about abuse history out of fear of being turned away for services. The contrast between respondents' substantial knowledge of HIV/AIDS and the lack of HIV/AIDS education and prevention programming may, in part, be explained by organizational impediments. Budgetary constraints, absence of expertise in the area of HIV/AIDS among staff, lack of an interdisciplinary approach, lack of client awareness of heightened risk of exposure, the ineffectiveness of traditional forms of protection in an abusive relationship, lack of HIV/AIDS programs as a scheduling priority, lack of hiring of additional staff, and the vulnerable state of a client's stage of recovery were stated as deterrents. Similar findings were supported in a qualitative study (Rountree, 2005) that identified organizational and client considerations as factors in the integration of these services in DV shelters.

Integration of HIV/AIDS services into service delivery would necessitate a commitment to staff training about client's heightened risk of acquiring STDs and HIV/AIDS education and prevention, with an emphasis on how to counsel clients about methods of STD prevention, treatment, and HIV risk reduction strategies in the context of abusive relationships. The mandatory safety planning process that staff assist client's in developing should include discussion on HIV/AIDS prevention. Dissemination of HIV/AIDS information to all women in shelters is a major step in heightening client awareness. Policywise, shelters need to develop guidelines to ensure the confidentiality of a client if the client self-discloses her HIV or AIDS status. If a women discloses having been sexually abused or having a positive status, referrals to statewide resources for HIV/AIDS counseling, testing, and treatment services should be made immediately. Counseling guidelines should be developed for staff to use if clients express concerns about HIV infection for themselves, their partners, or both.

Social workers can play a prominent role in educating colleagues and DV shelter leadership on these two intersecting public health concerns: (1) reorganizing the intake process to include a risk-assessment measure for HIV and (2) integrating HIV/AIDS education and prevention programming that are contextually relevant for women in abusive relationships (for example, negotiating strategies). Social workers can interface with HIV/AIDS agencies and service providers to advocate for integrating HIV/AIDS services and can invite funders, legislative, and community organizations to join the conversations. Furthermore, a revised empowerment model that provides information to

women, regardless of inquiry, should be considered a major topic for discussion by the state.

The response rate for this study was comparatively high at 64 percent, and there was representation from urban, suburban, and rural areas. Neuman and Kreuger (2003) reported a response rate of 10 percent to 50 percent is common for a mail survey. Personal contact and reminders enhanced the response rate, in addition to the \$500 incentive to submit surveys within a certain period of time.

The limitations of the project include the inability to generalize the study beyond the 21 respondents who submitted surveys. The sample was drawn from one southwestern state and reflects the unique nuances to the political climate, service delivery, and clients that are served.

Although the results of this study cannot be generalized to all shelters serving women who have experienced IPA, it offers insight into gaps in service delivery. Future research with a larger sample of shelters could further illuminate the findings from this study and result in better assessment within shelters of risk factors for STDs and HIV/AIDS. In addition, further large-scale research could substantiate the need for HIV/AIDS prevention and education that is contextually relevant and institutionalized as a standard of care within shelters.

CONCLUSION

Women are disproportionately affected by the intersecting phenomena of IPA and HIV/AIDS. Access to information related to their risk of infection and ways to keep themselves safe is power—power of information and power of choice. This study has provided insight into the absence of the availability of assessment of a client's risk of HIV/AIDS and HIV/AIDS educational and prevention programming in domestic violence service delivery. The recognition of the organizational impediments reported in the study does not negate the present danger to women who have experienced IPA and their increased risk of infection. Strategic ways in which to move beyond these barriers need to include collaborative efforts between DV shelters and HIV/AIDS organizations wherein expertise is shared and fiscal burdens are reduced. **HSW**

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Original manuscript received December 1, 2005
Final revision received October 26, 2007
Accepted November 1, 2007