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When HIV-Prevention Messages and Gender Norms Clash: The Impact of Domestic Violence on Women's HIV Risk in Slums of Chennai, India

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This paper examines how marital violence affects women's ability to protect themselves from HIV/AIDS. In-depth interviews ($n = 48$) and focus groups ($n = 84$, 3–7 per group) were conducted among men and women in two randomly selected slums of Chennai, India. The study showed that community gender norms tacitly sanction domestic violence that interferes with adopting HIV-preventive behaviors. Given the choice between the immediate threat of violence and the relatively hypothetical specter of HIV, women often resign themselves to sexual demands and indiscretions that may increase their risk of HIV acquisition. In conclusion, AIDS-prevention interventions must incorporate gender-related social contexts in settings where husbands strictly enforce their locus of control. HIV-prevention messages targeting men may effectively reduce women's exposure to HIV/AIDS.

KEY WORDS: Violence; women; HIV/AIDS; gender norms; India.

INTRODUCTION

Women constitute nearly half of the 37 million adults living with HIV in the world; they account for 55% of adult infections in sub-Saharan Africa and 30% in the rest of the world (UNAIDS, 2001). Whereas the biological factors that place women at risk for HIV infection have been well described (Dixon-Mueller and Wasserheit, 1991; European Study Group on Heterosexual Transmission of HIV, 1992), the sociocultural and structural factors that compound women's biological vulnerability to HIV/AIDS are often overlooked (Heise and Elias, 1995). HIV and sexually transmitted disease (STD) prevention efforts have consistently focused on two main messages: practice mutual monogamy and use condoms. However, in many societies, women's economic and social freedoms are constrained, leading to powerlessness to engage in these HIV/STD-preventive behaviors (Gupta and Weiss, 1993; Worth, 1989; Zierler and Krieger, 1997). These gender inequities are perpetuated by social norms that enable a palpable and dangerous manifestation of powerlessness: violence against women.

Sexual and physical violence against women is prevalent in many parts of the world, with the majority of assaults committed by intimate male partners (Ellsberg *et al.*, 2001a). Sexual violence by intimate partners occurs two to eight times more frequently than by strangers (Campbell, 1989; Shields and Hanneke, 1983). In addition to the immediate physical injuries (Grisso *et al.*, 1999; Kyriacou *et al.*, 1999; Romkens, 1997) and reproductive health problems (Cokkinides *et al.*, 1999; Curry *et al.*, 1998; Eby *et al.*, 1995; Martin *et al.*, 1999b; Parker *et al.*, 1994; Schei and Bakketeig, 1989) stemming from physical

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and sexual abuse, studies have shown that intimate partner violence is associated with STD transmission (Campbell and Alford, 1989; Martin *et al.*, 1999a) and HIV/AIDS (Maman *et al.*, 2002; Van Der Straten *et al.*, 1998). In Africa, for example, Maman *et al.* (2002) found that young HIV-positive women had a 10-fold increased odds of reporting physical violence compared to young HIV-negative women (odds ratio [OR] = 10; confidence interval [CI] = 2.7–37.4).

Violence has been shown to increase women's risk to HIV/STDs through three main routes (Maman *et al.*, 2000): (1) increased sexual risk-taking in women with a history of sexual abuse in childhood or adolescence (Choi *et al.*, 1998; Greenberg, 2001; Wingood and DiClemente, 1998; Wood *et al.*, 1998), (2) forced sex with an infected partner (Fisher *et al.*, 1995; Kalichman *et al.*, 1998; Molina and Basinait-Smith, 1998; Wingood and DiClemente, 1998), and (3) women's inability to negotiate condom use (De Zoysa *et al.*, 1996; Eby *et al.*, 1995; Goldstein, 1994; Karim *et al.*, 1995; Wingood and DiClemente, 1997). However, empirical data on the effect of violence on women's ability to insist on mutual monogamy or to refuse sex with a nonmonogamous husband are scarce. At a broader level, few studies have examined the relationship between the sociocultural environment that fosters domestic violence and its impact on women's risk for HIV and other STDs.

In India, where wide gender gaps are deeply embedded in the social structure, women may be particularly vulnerable to violence. In this patriarchal, patrilocal, and patrilineal society, the family, headed by the oldest male, is central (Bhatti, 1990). Women's subordinate economic and social position within this structure can be traced to ancient India (c. 1500 BC), when Kautilaya, Manu, and Smriti philosophers called for absolute subservience of women to their husbands (Mahajan, 1990b). According to their writings, the husband retains absolute control over his wife's mind and body and has "the right to use physical corrective methods over his erring wife" (Mahajan, 1990a, p. 120). Texts from this period suggest that wife beating was considered a part of everyday life. Tulsidas, an ancient Indian poet, wrote, "As part of a primitive, uncultured caste, animals and women deserve to be beaten regularly" Mohan, 1990, p. 12). These norms have been perpetuated by inheritance, property, and divorce laws that favor men, who continue to govern the economic, social, and sexual realms within households (Jejeebhoy, 1998).

Data suggest that women's inferior position in society increases their risk to violence. The proportion of Indian men who report ever beating their wives is high, ranging from 22% in southern rural villages of Karnataka (Rao, 1997) to 75% in lower caste communities in northern Punjab (Rao, 1997). Several surveys and case studies on wife beating in India have examined domestic violence (Bhatti, 1990; Jain, 1992; Jejeebhoy and Cook, 1997; Kaushik, 1990; Martin *et al.*, 1999a; Maydeo, 1990; Miller, 1992; Nandi *et al.*, 1985; Singh, 1986); however, few have used qualitative methods (Rao, 1997). To our knowledge, no studies have examined the potential relationship between traditional gender norms, violence, and vulnerability to HIV/STDs. A study conducted by Roth *et al.* (2001) suggested an association between gender inequities and condom use in Mumbai; however concrete mediators of this relationship, such as violence, were not explored.

Although reported HIV/AIDS prevalence rates among the general population of women in India are relatively low (Celentano *et al.*, 2001), recent studies have documented an increase in HIV among monogamous married women (Gangakhedkar *et al.*, 1997; Newmann *et al.*, 2000). The rising rates of HIV infection among Indian women underscore the need to contextualize the meaning of domestic violence and to determine how this may influence women's ability to protect themselves from HIV/AIDS.

This paper addresses five main questions: (1) What are the traditional gender roles in Chennai slum communities? (2) How extensive is the problem of domestic violence? (3) How does the relationship between gender roles and violence affect women's ability to practice HIV-preventive behaviors? (4) What recourse do women have in response to violence? (5) What are the implications of violence on the development of effective HIV prevention interventions targeting women?

METHODS

This paper reports findings drawn from a National Institute of Mental Health (NIMH) multisite, international, randomized-control trial of an HIV prevention intervention. In India, the research venues are low-income, urban residential areas ("slums") in the southern city of Chennai in Tamil Nadu State. Formative research for the trial was conducted in two randomly selected slum communities that are not included in the intervention trial but are otherwise socially and demographically similar to the trial venues. These communities are the source of information

collected and reported on here. To guide our research, we drew from Heise's multilayered theoretical model (Heise, 1998), which considers individual- and social-level factors as determinants of partner abuse. We modified Heise's model by shifting the focus from the perpetrator to the victim of violence in order to examine the interrelationship between gender norms, domestic violence, and women's HIV-preventive behaviors.

In-depth interviews and focus group discussions among men and women were conducted to explore domestic violence. Focus group discussions examined normative attitudes and perceptions of domestic violence in the slum community, whereas in-depth interviews probed domestic violence as personally experienced by participants. The research protocol, field guides, and consent forms were reviewed and approved by the local institutional review board, the Johns Hopkins Bloomberg School of Public Health's Committee on Human Research, and the National Institutes of Health's Office for Protection from Research Risks.

Study-eligible women and men were residents of the project slums, aged 18–40 years, and capable of providing oral informed consent. Participants were initially recruited into the study through referrals from local community leaders; later rounds were identified through referrals from participants.

A team of three male and three female trained ethnographers conducted interviews in a private place in or near the homes of participants. Interviews lasted approximately 1.5 h. Interviews were tape-recorded, transcribed in Tamil, translated into English, and entered into Atlas TI (Muhr, 1997) for data analysis. The data were reviewed for main themes and then coded for retrieval and analysis. Coded text was organized into matrices to facilitate comparison across different categories of informants.

RESULTS

Forty-eight interviews (23 women, 25 men) and 14 focus group discussions (7 of each gender) were conducted between October 1, 2000 and February 5, 2001. Focus groups consisted of three to seven same-gender adults from the community. Of the female groups, one was of unmarried participants and six were of married women; of the male groups, three were of unmarried men, two were of married men, and two groups consisted of both married and unmarried participants. The mean ages of men and women were 26 and 28 years, respectively. Eighty-percent of the women were married compared to approximately 38% of the men, and 32% of women and 11% of men had received no education. Results are organized into the following sections: (1) traditional gender roles; (2) descriptions of violence; (3) the interrelationship between gender norms, violence, and HIV/STDs; and (4) recourse in response to violence.

Traditional Gender Roles

The Ideal Man

Participants agreed that, foremost, a man must be the family's provider. In that role, he is responsible for maintaining the family's reputation in the community: "A man should have a permanent job. He should earn well and should earn a good name for his parents" (unmarried male, age 18, focus group). During discussions, male participants emphasized a man's obligation to "improve society" (married male, age 41, focus group), whereas women highlighted the importance of resisting "vices," particularly excessive drinking: "He should not drink and should not have any relationships with [other] women" (married female, age 28).

The Ideal Woman

Men's and women's descriptions of the ideal woman converged on three behavioral characteristics. A woman should be disciplined, submissive, and respectful, particularly with respect to the husband. According to one participant, "A woman should be respectful to others. She should be timid and should look after her family. She should be obedient to her husband and should look after her children and should not have conversations with others unnecessarily" (unmarried male, age 20).

Men highlighted additional desirable female characteristics. Many added that a woman was expected to accept her husband's imperfections and to put his needs in front of her own: A woman should "look after the husband ... even if he makes a mistake, she should look after him at home" (married male, age 41). In addition,

> Women are first to listen to what the husband is saying ... when her husband comes from work, whatever problems she is having at home, she should be warm and welcome the husband from work; she should be

> patient and even if the husband is angry, she should understand what is wrong very patiently. Because even if the husband has had a bad day, it is up to the wife to actually lighten the mood by patiently asking what is wrong. (Married male, age 37, focus group)

Several male participants also emphasized the importance of chastity. For example, "A woman should value her purity as if it's her life" (unmarried male, age 22, focus group). In addition, male participants frequently alluded to women's role as caretaker: "She should look after the family needs and feed those who visit the home" (married male, age 34), "She should maintain her home well" (married male, age 25), and "When the husband comes back from work, she should provide him with tea or coffee and keep the water ready for his bath" (unmarried male, age 24).

Descriptions of Violence

Behavioral guidelines for men were not strictly enforced; most women agreed that "Men will do what they please and no one can question them" (married female, age 37, focus group). In contrast, a wife's transgressions can lead to marital conflict. Both men and women reported that in most marriages, conflicts often resulted in verbal, physical, and sexual violence against the wife. Interviews suggest that violence against women in the slums is widespread. According to a woman in a focus group discussion, "90% of men beat their wives." Another explained,

> I have been living in this area since after my wedding and so I know what is going on here. Men are not bothered that their wives are women or that people are watching or that the women's clothes are getting torn. They hit their wives mercilessly . . . there is not a woman in the community who has not been hit by their husbands after drinking. In fact, people hide in other's homes to escape from the blows. (Married female, age 30)

Despite the perceived pervasiveness of violence, exceptions were noted: "There are men who work, come back home, and attend to the wife's needs and look after her well" (married female, age 26). Another agreed, and added, "My husband looks after me well and does not hit or torture me in any way. We are friendly and loving" (married female, age 22, focus group).

Women who reported physical violence described shoving, face slapping, kicking, hitting the head against the wall or floor, and burning with lighted cigarettes; some reported being struck with objects such as a wooden ladle, knife, or stone: "They will hit with the hand or with some stick or broom. Or if they lay their hands on some object, they will throw that. Or with a knife . . . They will hit with what ever they get their hands on" (married female, age 30, focus group).

Slapping and hitting the face and head were the most frequently reported forms of violence. Some women suffered permanent health sequelae such as recurring headaches and blurred vision: "He will knock my head against the wall or hit my head with a wood piece. Once he hit me with a wood piece and it was so heavy that even now I keep getting headache due to that. His hands are rough and when he slaps me hard on my cheeks, I am not able to see properly" (married female, age 29).

Men and women listed similar triggers to beatings, including disobeying the husband or elders, neglecting household chores, refusing to have sex, and suspected infidelity. One woman describes how violence is triggered:

> He gets angry and beats me when he is not happy with the food made at home. He is very particular that rice should not be overcooked and with different food except sambar [a dhal-based accompaniment for rice]. When served every day, he grumbles. If the rice is a little overcooked, then he will immediately begin the fight shouting that I have wasted my time gossiping with people outside." (Married female, age 38)

The Interrelationship Between Gender Norms, Violence, and HIV/AIDS

The link between gender norms and violence in Chennai slums increases women's risk to HIV/AIDS by limiting their ability to discuss her husband's infidelity, refuse sex, or negotiate condom use.

Discussions About Husband's Fidelity

Men and women conveyed that norms permit a double standard for extramarital sex; it is tolerated for men and proscribed for women: "Normally people do not talk ill of men when they have an extramarital affair" (married female, age 24, focus group). Men expressed a similar view: If a woman has extramarital sex,

> they will brand her a prostitute and even if she comes to the community tap to collect water, they will speak

> about it or ask her. But they will not speak about the man. He will walk around with pride and will talk of the women he visited and will also ask if he has any shortage for women. But even for a small issue, they will talk of her. They will think his manliness has increased by his contact with so many women. Is it not a matter of pride if a man has sexual contact with four women? But a woman cannot have contact with four men. It would be a shameful to her and so they speak like this. (Unmarried male, age 24)
>
> As a man, I can go to anyone, but a woman cannot go to another man as this will mean that she is a prostitute. I cannot allow that because people might say that I am a pimp who is making his wife earn and that he eats from her money. If she does this, I should send her straight to heaven [kill her]. I can do anything I want, but I cannot let my wife do all this. (Married male, age 22)

In the context of norms that sanction men's extramarital affairs and encourage women's submissiveness, initiating discussions about a husband's fidelity is problematic: "When the husband is unfaithful, then it is the duty of the wife to stay with the husband and be faithful and true no matter what happens. And if the wife questions the husband, then there are going to be a lot of problems. There will be lot of fights in the house. So whatever happens the wife should be able to bear it" (married woman, age 38).

Several women explained how violence was a barrier to discussing their husbands' sexual risk behavior with them:

> mmm. I have not asked him ever why he is doing all this [having sex with other women] openly because I am scared he will abuse me verbally and hit me. I thought if I ignore him he will change [his behavior] on his own. He also had sexual contact with his brother's wife and she was his mistress. He used to "join" [euphemism for having sex] with her. I could not ask him anything. (Married female, age 35)

Refusal of Sex

Refusing to have sex with a nonmonogamous husband is not a viable HIV-preventive strategy for women. Most female participants and all male participants explained that a wife is expected to respond to her husband's sexual urges: "He is, after all, my husband and not some other person. He is my husband and when he likes to have sex, I must go" (married female, age 25). Although some women could decline sex without incident, the majority of participants stated that refusal or attempts to negotiate sex could lead to violence:

> Once I was drunk and she refused [to have sex] and in that anger I hit her. Then she corrected herself and I told her that when a man has sexual urge, the woman must reduce that. But she did not seem to understand that and so I had to hit her. (Married male, age 27)
>
> He will ask me to come and "sleep" [euphemism for having sex], but I will tell him some excuse like stomach pain or fever. But even then, he will not allow and he will hit me . . . I used think I would rather die. (Married female, age 27)

Many women reported that in order to avoid violence they acquiesced to sex, even if it placed them at risk for an STD:

> He used to force me to have sex and if I did not agree, he would grit his teeth and sit up . . . I would have to change my mind and have sex. (Married female, age 29)
>
> She has sex with everyone. [So] I thought to myself, if my husband has sex with her and if he has sex with me, won't I also get some disease? Or is he already having some disease was my other worry . . . [Yet], if I did not give in to sex with him, he used to force me more and so I used to adjust myself accordingly. (Married female, age 30)

Alcohol intensifies the relationship between marital sex and violence:

> When he comes home drunk, he has violent sex with me . . . when he is not drunk [sex] is quick and it's nice too; it's not difficult. But when he drinks and has sex with me, I feel as though I am in hell and he is purposely torturing me. He has sex with me for a long time and does not move away. I am not able to bear it, yet if I move away to the corner he catches me and pulls me towards him and also he holds my hair and violently yanks it. (Married woman, age 28)

Although men explained that they drink to relieve work-related stress, they admitted that alcohol often has the reverse effect, heightening their tensions and predisposing them to outbreaks of violence: "They may have some anger related to work which becomes unbearable after drinking, so when they come home, they hit the wife for the smallest reason" (married female, age 27). At the same time, men believed that alcohol, consumed in small quantities, increases their sexual drive. The synergistic interaction of sex, violence, and alcohol significantly increases a woman's risk to violence if she refuses sex:

> Men, when they drink, they come home and they want to have sex with their wives. When the women are not willing, they beat their wives. (Married female, age 25)
>
> Many times, due to work related tension, I come home drunk and she will not let me get close and my mood will be upset. I will have the interest, but

> she will not allow me and so I will force her to have sex. (Married male, age 27)

Condom Use

Although female participants widely acknowledged that condoms would protect them from HIV/AIDS, examples of successfully negotiated condom use by women were rare. One woman explains how she initiated condom use with her husband: "I have used [condoms] many times. When I see my husband talking to me in a nice way, then I will tell him if you have condom, then you can come and sleep with me" (married female, age 30, focus group).

More commonly, women described how violence inhibits them from negotiating condoms, even if they perceive themselves to be at risk for diseases. Specifically, a woman's initiation of condom use is seen as a sign of insubordination, or more commonly, as a sign of her infidelity; both are common triggers to violence:

> Since he has been traveling and in case he has been to some women . . . I will be scared of what could happen. So I will tell him to wear [a condom] and he will retort saying that he would slipper [hit] me if I suspect him of cheating on him. So I will also trust him and we will have sex without any protection. (Married female, age 27)
>
> If I ask him to use a condom, he will hit me. He will ask if I am doing all this and if I have gone to have sex anywhere else. Once I have asked him that since he's going out and doing all this [having sex with other women], why doesn't he use some protection and he has hit me with a wood. From then on I did not ask him anything. I left it to his wish. (Married female, age 35)

Men's comments echoed women's experiences: "If a woman suggests that he use a Nirodh [brand name of condom], he will hit her" (married male, aged 28, focus group).

Even intervention by a third party may be unsuccessful in overcoming these norms. One woman who contracted gonorrhea from her husband was unable to negotiate condom use with her husband, despite their doctor's advice:

> [The doctor] gave [my husband] condoms and said "until both of you are fully cured, please use this condom when you have sex." So, when we left the hospital and went home, I used to ask him to bring a condom home. He will say that I am unnecessarily trusting whatever the doctors have told me. He will not bring the condom and when I insist, he used to shout and hit me. (Married female, aged 27)

Recourse to in Response to Violence

A few female participants devised strategies to escape or minimize violence. One woman remained silent if her husband berated her, because "If I answer back, he will hit me. If I am quiet, he will leave me alone" (married female, age 24). Others distracted their husbands or temporarily left their homes in order to avoid a potentially violent episode:

> Sometimes, when the food is slightly overcooked and when I know that my husband is terribly angry, I am prepared that he is going to beat me that day. But I will try my best to keep his attention away from the food by talking to him about something that happened in the community that day . . . something interesting. I know that if he notices that the food is bad, then he will throw the food at me and tell me to eat it. (Married female, age 38)

However, these solutions were temporary and often ineffective. The vast majority of female participants stated that financial constraints rendered few options available to women who experience violence:

> When the men get angry, what can the women do? I mean there can be brothers and parents living in the same community and we could go to them for help, but for how long? How long will they support us? How long can they afford to look after us? When the parents or the brothers ask us to leave the home, who will take care of us or who will take us back? So, some day, we have to go back to our husbands whether he beats us or not. Because he is who is going to feed us. (Married female, age 35, focus group)

One woman who lived alone with her children, disagreed, explaining,

> I was married when I was 14 . . . I used to have the same problem as her [pointing to another woman in the group whose husband frequently and severely beat her] . . . until one day I could not take it anymore so I told him to get out and I told him that I will survive by earning and that I don't need his help. I sent him away and he has not come here after that. (Married female, age 36, focus group)

However, after some discussion, the group reached consensus that such instances were very rare: [If a wife leaves her husband] and if he knows that she is here, he will come back and beat her and he will not allow her to work or live peacefully" (married female, age 30, focus group).

In addition, women highlighted a range of social factors that prevent women from leaving abusive relationships:

> Society will never respect a woman who leaves her husband . . . so it is better to suffer and die with the man who has tied the *thali* [tying a gold chain around the neck symbolizes marriage]. (Married woman, age 40)
>
> For a woman to survive in a community like this is very, very difficult. There are men who will give her problems because she is living alone. She will have more problems because she has left her husband because the men will think that she is available and ready. (Married female, age 38)
>
> They will say that she has left her husband because she is *vazha vetti* [a person who has nothing to do and does not have a life]. (Married female, age 30, focus group)

DISCUSSION

HIV prevention interventions have focused on two main messages: Practice mutual monogamy or use condoms. These interventions assume that the target populations *can* modify their behaviors. Research reports have questioned this assumption, suggesting that unequal power relations between men and women in many societies limit women's ability to protect themselves from HIV and other STDs (Gupta and Weiss, 1993; Heise and Elias, 1995; Piot, 2001). Although research has suggested associations between violence and HIV/STDs (Campbell and Alford, 1989; Martin *et al.*, 1999a; Van Der Straten *et al.*, 1998) and violence and condom use (Eby *et al.*, 1995), studies that have explored the factors mediating these relationships are rare.

Our research contributes to the literature on violence and HIV by showing, through men's and women's own words, that HIV-preventive behaviors for women may directly conflict with community gender norms and that this clash may lead to marital violence. Given the choice between the immediate and tangible threat of violence versus the relatively hypothetical specter of HIV, women in Chennai slums often resign themselves to a husband's sexual indiscretions and sexual demands.

According to our participants, physical and sexual domestic violence is widespread in the slums of Chennai. Contexual factors such as pervasive unemployment, illiteracy, and poor living conditions in the slums can exacerbate domestic violence by increasing marital stress; these links have been reported elsewhere (Go *et al.*, in press). Participants described a range of physical violence from shoving to cigarette burns. Violence is triggered by perceived transgressions in traditional gender norms, including incompletion of household chores, disobeying a husband or parent-in-law, refusal to have sex, and suspected infidelity.

Participants described strong social norms that govern every-day gender-based behaviors. As the main provider, men are expected to ensure the family's social and economic well-being. Although women suggested that men should avoid "vices" such as drinking and visiting sex workers, these guidelines were not socially enforced. In contrast, gender norms guiding women's behaviors were clear. A woman should be submissive, obedient, and respectful. In her primary role as family caretaker, she is expected to remain deferential and loyal to her husband. These norms were strongly enforced for women in our study population, often through the use of perceived and actual violence.

Gender norms have important implications for women's ability to practice HIV-preventive behaviors. Our data suggest that marital communication about fidelity, marital sex, and condoms are almost exclusively initiated and controlled by the husband. Because gender norms sanction male infidelity, women are expected to overlook their husbands' indiscretions and to care for them unconditionally. Furthermore, women are expected to respond to their husband's sexual urges; discussions about sex are rare and considered inappropriate. Finally, wife-initiated condom negotiation is perceived as nonnormative because it raises suspicions of her infidelity. Efforts by women to practice nonnormative self-protective behaviors place them at risk for domestic violence. In corroboration with other studies, our study suggests that fear of partner retribution may prevent a woman from negotiating condom use with a husband whom she suspects may be infected with HIV/AIDS (Eby *et al.*, 1995; Karim *et al.*, 1995; Wingood and DiClemente, 1997). Our study expands these finding to show that violence is a barrier to discussing fidelity and refusing sex. Contrary to the coping strategies that enabled Nicaraguan women to escape abusive relationships (Ellsberg *et al.*, 2001b), we found evidence that economic dependence and social pressures limit women's recourse to violence in India (Jejeebhoy and Cook, 1997). Finally, the synergistic relationship among alcohol, sex, and violence may further place women at risk of HIV/AIDS. Drinking is common in the slums and our study supports Rao's (1997) finding that alcohol often intensifies sexual violence.

There are some limitations to our research. The small sample size and nonrandom sampling procedures prevent the generalizability of our findings to

other populations. In particular, results of this study are not generalizable to rural populations and to middle- or high-income urban populations in India. Because our study focuses on violence within marriage, other relationships, such as premarital, extramarital, and commercial relationships, were not represented. Nevertheless, this study presents rich narrative data on a sensitive topic expressed through people's voices.

In conclusion, these findings highlight the importance of recognizing social contexts when developing HIV/STD prevention interventions. In the Chennai slums, violence against women is an embedded social limitation that hinders women's ability to protect themselves from HIV/STDs.

In order to reduce women's immediate risk to HIV/STD infection in male-dominated settings, HIV messages promoting condom use and monogamy should target men. At the same time, long-term, multipronged approaches are needed. Development of an effective microbicide may be critical in settings where domestic violence is pervasive because microbicides can offer women a way to covertly protect themselves from infection without having to negotiate condom use (The Microbicide Initiative, 2002). In addition, efforts are needed to create an environment in which women are able to protect themselves from HIV and other STDs. As our study demonstrated, this may require changing gender norms that sanction violence. Toward this end, community-based activities such as street plays conducted by a local theatre group (Harvey *et al.*, 2000; Skinner *et al.*, 1991) or audio dramas (Maticka-Tyndale *et al.*, 1994) could be developed to raise awareness of domestic violence and its health consequences. In addition, sessions that include interactive role plays on conflict resolution and programs that target expectancies surrounding alcohol use (e.g., increase of sexual drive, release of physical and psychological tension) may be effective in reducing both alcohol- and non-alcohol-related outbreaks of violence. Interventions that provide women with the tools to elevate their economic status (e.g., micro-enterprise projects) may psychologically and economically empower women to leave abusive relationships as a response to violence (Jewkes, 2002). In order to capitalize on clinic visits, we recommend cross-training for HIV and STD counselors and domestic violence workers. HIV voluntary testing and counseling centers and STD clinics could incorporate a domestic violence prevention component into HIV/STD counseling sessions and domestic violence counselors could educate their clients on HIV and STD prevention. Untangling the web of HIV and violence is neither simple nor quick; changing gender norms that mediate this association will require prolonged, multifaceted, and community-based approaches. However, unless violence is recognized and addressed, HIV prevention efforts targeting women in the slums of Chennai, India, may prove ineffective.

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